TRUTH AND RECONCILIATION COMMISSION

HUMAN RIGHTS VIOLATIONS

HEALTH SECTOR HEARINGS

DATE: **17 JUNE 1997**

HELD AT: **CAPE TOWN**

DAY 1

ARCHBISHOP TUTU OPENS THE HEARING

CHAIRPERSON: It's a bad thing to do but we start with an apology. We are waiting for some of the presenters who have not yet arrived and we are sort-of at the moment re-adjusting the schedule to some extent, so I hope you will bear with us for a little bit.

WELCOME IN AFRIKAANS: I would like to welcome you all to this public hearing of the Truth and Reconciliation Commission. This is the first in a series of sittings.

WELCOME IN XHOSA: We welcome you all to this Truth and Reconciliation Commission hearing. We welcome you all very warmly to this hearing of the Truth and Reconciliation Commission.

This is the first in a series of professional or institutional hearings and in this one we intend to be looking at the role of the health sector in perpetrating, colluding with or resisting human rights abuses during the period under review. This is perhaps appropriate as the TRC is so often described in terms of medical metaphors, opening wounds, cleansing and healing. There has been very considerable support for and interest in these hearings both locally and internationally. This is very encouraging and we are most grateful for this.

I want to express our appreciation especially to the special task group that has put together the hearing and been responsible for eliciting contributions from various people.

I also want to say a very big thank you to my colleagues, Commissioners and Committee members and also staff persons for all they have done.

Thank you to the Police who had their dogs come through sniffing to ensure that no one wanted to send us to "Kingdom Come".

Two years ago I was at Nuremberg, part of a BBC panel discussion on the legacy of the Nurem-

berg trials fifty years or so ago. We met in the very court room in which the trial had taken place. I am not wanting to evoke any special associations or responses by reference to this.

After the session in the court room I visited the nearby Dachau site of one of the notorious concentration camps of the Third Reich. It contains a museum of what happened there in the times of the Nazis. And then at the entrance you will find the haunting words,

"Those who forget the past are doomed to repeat it".

I was appalled by certain photographs that were on display in that museum at Dachau. Some showed inmates having been constrained to play their band clearly leading one of their number to be executed by a firing squad. And there are pictures also of some of the prisoners being strung up on trees by their hands manacled behind their backs, exquisite torture.

The Germans ever so methodical took pictures and kept immaculate records that were later to incriminate and were used perhaps to convict them, very much like a picture that appeared on the front page of The Argus of three police officers seemingly with a trophy after their hunt.

Then a little further on in the museum were pictures of people caught in grimaces and with their faces distorted in experiments, some of which were to see how much depth the human person could stand or how much altitude decompression. And one recalled too how you had accounts of psychologists in the Soviet Union keeping dissidents as certified inmates.

I didn't think here in South Africa we might be so blatant. I myself have a very high regard for the medical profession in our country whose very high standards compare favourably with those in other countries. After all we pioneered things like heart transplants.

And just as an aside people might want to know that the President called me in to give me a gentle ear-full about going to the United States for treatment. I do want to point out that I myself would have wanted to receive all of my treatment here, though in consultation with a panel that includes two Professors at UCT Medical School, their consensus was that I should accept the offer that was made by the Sloane Kettering Kensa Institute and I buckled under the pressures from the rest of my family. But I would like you to know that there is very close collaboration between the medical team here and the medical team overseas.

What we have heard that there has been collusion between healers and the security forces. And

outstanding instance being the Steve Biko case when doctors appeared not to have given the welfare of their patients the priority that we would have expected them to have done. That is the sombre side.

There is a bright side in the witness of the medical profession where people like Professor Ames and others ensured that people who had behaved, in what was to their view, unethical conduct, were to be brought to book. And sitting next to me is my colleague here who was very instrumental in getting an interdict against torture, against the police, to prevent them from torturing detainees so that there are very, very considerable bright spots.

May I quote from a Professor Ralph Kirsch.

> "True healing demands that we examine, face and record the acts of commission as well as omission of the medical profession.
>
> We have recently been reminded that membership of the health care profession includes the responsibility for what we ought to do, an ought that derives from dealing with people who are in a dependent, vulnerable, exploitable state of weakened humanity.
>
> In this context we all share the blame of those physicians who assisted in the torture of prisoners, falsified reports or suppressed knowledge of mistreatment.
>
> Facing our past failures will, we hope, increase our resolve to meet the responsibilities of our profession".

I want to pay a very warm tribute to all of those in the health care professions who have distinguished themselves, among other things, through working in deprived areas, those who at very great cost to themselves supported instances such as the End Conscription Campaign. What we are about is to say this is what happened. This is part of our history good and bad. And that we may emerge from these hearings with suggestions, perhaps our safeguards that will ensure that the awful things that we will be hearing about do not happen again. That we face the past honestly, acknowledging responsibility for the frequent failure of the health sector to uphold human rights, celebrating those who did fight for their patient's rights and facing the future not only with the resolve to prevent the violations of the past, but with firm recommendations on how to ensure non-repetition of past atrocities.

May I, in conclusion, introduce my panel colleagues. Dr Fazel Randera is Commissioner and member of the Human Rights Violations Committee and he is our regional convenor in our office in

Gauteng. Glenda Wildschut is a Commissioner and member of the Reparations and Rehabilitation Committee and she is based in our office here. Pumla Gobodo-Madikizela is a member of our Human Rights Violations Committee and is based in our office here. Denzil Potgieter is a Commissioner, a member of the Human Rights Violations Committee. He is probably going to be moved to another Committee. Then Alex Boraine, the Deputy-Chairperson of the Commission, based here. Wendy Orr, Commissioner, Deputy-Chairperson of the Rehabilitation and Reparations Committee based here and she is also our boss-woman here. She is the regional convenor in this office. Dr Mapule Ramashala, a Commissioner, member of the R & R Committee and based here. Hlengiwe Mkhize, Chairperson of the R & R Committee based in Gauteng.

I'd like to hand over to Wendy who is going to welcome specific persons.

DR WENDY ORR: Thank you Father. We have so very many special guests here today that it is impossible to welcome each one by name. We do, however, have a number of international visitors and we are deeply grateful to them for taking the trouble to come all this way to participate in the hearings and to add their support and hopefully their on-going support as we prepare our final programme and recommendations.

I just want to comment particularly on the context of these hearings. I think there have been accusations that the Truth and Reconciliation Commission is going beyond its mandate by exploring the health sector, the judiciary, the education sector, but in fact our mandate is very clearly spelled out, **to examine the context, perspectives and environment within which human rights violations occurred**, and to make recommendations to ensure that those violations do not happen again. And it is within that context of our mandate that we are holding these institutional and professional hearings.

This process started a long time ago. In August last year Fazel and I were charged with putting together a health sector hearing and to that end we had a national consultative workshop in November at which we discussed the issue with a number of major role players and decided that it would be appropriate to hold health sector hearings at which we would hear submissions from a number of major role players.

We have tried to structure the day by starting off with case studies to demonstrate real life situations in which things went wrong. In which complicity and collusion, negligence, mistreatment and violations occurred and then moving into the organisational submissions to try and help us understand the

context and environment within which these occurred, why they occurred, how they occurred and most importantly, and I feel very strongly about this, how we can prevent them from occurring in the future.

We are going to have to change the order of the case studies just a little bit because Mrs Ntsiki Biko and her brother-in-law, Steve's brother, Mr Kayo Biko will be arriving any minute. Their plane was due, SAA willing, to arrive at 10 o'clock, so we are hoping that they will be here soon, but we obviously can't have our presentation of the Steve Biko case study without Mr and Mrs Biko being here. So we will be starting with Case. no.3 on your programme which is the Detainee case studies.

Before I move into that I want to say thank you to two very special people without whom these hearings would never have happened. One of them is here and is Sheila Roquitte who is a research intern from Princeton, who has been my right-hand, my left foot, my head, my eyes, my sanity in the last few months as I've been working towards these hearings and I want to say a huge thank you to her.

The other person is not here, she is Linda van Demen, my secretary, who turned her office into a printing press to try and produce copies of all the submissions so that people had a chance to read them beforehand and prepare questions around them.

We received almost 50 submissions and they are still coming in, so there is obviously tremendous interest in this issue. It highlights the fact that we need to break the culture of silence, the taboos which have surrounded the medical profession, the mystique of the medical profession, the fact that people don't speak out, the fact that doctors are viewed as a closed club very often who stand up for each other rather than for their patients and that's really what these two days are all about. It's how we can break that culture of silence and move together into the future.

I'd like to ask Nomfundo Walaza and the witnesses whom she is bringing with her to come forward and do our first presentation on Detainee Case Studies and Glenda Wildschut is going to be facilitating their evidence.

DETAINEE CASE STUDIES

MS WILDSCHUT: Nomfundo before we start may I ask that Mrs Lesani and Mrs Gcina please stand to take the oath and we will ask Denzil Potgieter to administer the oath. Are you going to be testifying as well Nomfundo? Okay, alright, then you can take the oath as well.

ADV POTGIETER: Thank you. Can I just ask you to state your full names for our record before I

administer the oath to you and would you mind just switching on the microphone in front of you. Thank you.

NOMFUNDO WALAZA: (sworn states)

MILDRED LESANI: (sworn states)

IVY GCINA: (sworn states)

MS WILDSCHUT: Welcome Nomfundo and Mrs Lesani and Mrs Gcina. I would just like to find out whether you would prefer to speak in your own language, because it is possible, we do have people who can interpret.

MS WALAZA: Yes, we will speak in our language, in Xhosa.

MS WILDSCHUT: You will speak in Xhosa.

MS WALAZA: Yes.

MS WILDSCHUT: If you are going to be speaking in Xhosa will you please put on your earphones because I am disastrous at Xhosa.

Nomfundo just a minute, I just would like to make one housekeeping announcement. These earphones, if you do not understand Xhosa you are going to have to use these earphones. Channel 1 is Afrikaans, 2 is English and the 3rd is Xhosa. We do not have enough earphones so those people who understand all three languages or English and Xhosa please share that with those who do not understand.

I have just been asked to make one small announcement to the witnesses but could people who have cellphones please switch them off. I have just switched off this one now. Can we ask those who do have cellphones please to switch them off.

And for those people who have to leave the room if you could please leave the room after the witnesses have given evidence, it's very disturbing to give evidence while people are moving around in the room. Thank you very much.

Thanks for your patience. Nomfundo I believe that you are going to give a short statement and

then we will move over from your statement to Mrs Lesani. Thank you, please go ahead.

MS WALAZA: Thank you very much Glenda. I think the first thing that I felt that was important to do was to contextualise this case study and in a way give a reason why the Health and Human Rights Project had decided to ask Ivy Gcina and Sheila to talk today.

The death in detention of Steve Biko was a critical moment in the history of health and human rights in South Africa because that created schisms in the medical and other professionals that remain to this day. His death led to an increase, according to some researchers, of the number of visits made by district surgeons to political detainees. And his death led to a few minor reforms that in retrospect had little impact on the health care of detainees.

But what is most ironic about the furore over the Biko doctors is that the highly publicised case did not prevent further deaths in detention or torture for the next 20 years.

In our submission to the TRC, the Health and Human Rights Project draws attention to more than a hundred cases of detainees ill-treated by doctors, nurses, psychologists while detained under security legislation. A phenomenon, we believe, was widespread in apartheid South Africa.

Former detainees had told us numerous stories about inadequacies of the custodian care system; doctors failing to take adequate medical histories; district surgeons refusing to listen to their complaints; medics pronouncing them fit for torture and further interrogation; physicians handing medical files to the security police; nurses deliberately withholding treatment or shackling detainees to their beds; psychologists violating the confidentiality of their patient for security reasons; doctors neglecting to keep proper clinical records and failing to follow up a prescribed course of treatment. And this list goes on.

In fact there are probably as many complaints about health care in detention as there were detainees in South Africa. Each one has a story to tell, and their voices have been conspicuously absent from the TRC hearings.

There is one woman, however, who did not leave enough to tell her story. A 50 year-old political activist and diabetic she died in 1987 as a result of the gross negligence of prison officials, security police, district surgeons and nursing staff. Her name was Nomabanda Elda Bani and she was detained on the 29th of August 1986.

I think the reason, as I said, why we chose this case as the Health and Human Rights Project is that

we felt that the medical, her medical reality was denied by health professionals. She had severe insulin dependent diabetic and she was told to eat sweets and take sugar. Her treatment was withdrawn at the time that she needed the most assistance. She was left in a coma for days before her death. For weeks she was incontinent, and her cell mates who are here to talk on her behalf today, had to witness the humiliation that she had to endure as a result of medical negligence. And in a way we feel very strongly that the medical professionals contributed to her death and actually forced her to her death bed.

And it is with that, that I, at the present moment, want to introduce the two women to tell the story of how she suffered in detention. We asked her former cell mates to describe the circumstances which led to her death in 1987 after her one year in detention.

It is my honour and my privilege to introduce the two women from the Eastern Cape. Ivy Gcina, who is currently a member of Parliament, she was the longest detainee at the time during the state of national emergency, she spent 35 months in prison. And Sheila Lesani, who is at the present moment at home, she is very important in the sense that she is a diabetic and she accompanied the patient to hospital most of the time that she had to go. So I will hand over to them to tell the story of what happened during that time. Thank you.

MS WILDSCHUT: Thank you Nomfundo. Mrs Gcina you can use the mike in front of you. I think you are going to be speaking first.

Thank you very much for coming and we really do want to pay tribute to Elda Bani today. We know that she suffered and you were her co-mates and suffered with her, so please go ahead and in your own words and in your own way please tell us the story of Elda Bani and also your own story. Thank you.

MS GCINA: Thank you. I would like to greet everybody here and I would like God to give you strength because after all the things that happened to us during the apartheid period we did not know that there would be people like you who will find out the truth so that we can forgive those who did these things to us. But I would like to ask Sheila, as she was the person who was together with Elda Bani in prison and they were in a single cell together, they were then transferred to the hospital in the Northern Prison in Port Elizabeth.

I will start on the 12th of June 1987 where they were transferred to my cell. I will help her as we are going to testify on behalf of Elder Bani I will hand over to Sheila and then continue afterwards.

MS LESANI: I would like to greet everybody here. I am Sheila Lesani who was detained on the 16th of July 1986 in the Northern Prison. I stayed there for a long time. Mrs Bani came on the 29th of August. We were then together in that cell. We were both diabetics.

The first thing was that we did not have a toilet in our cell. There was a bucket there. As we were diabetic we would eat and Mrs Bani would eat and we were supposed to go frequently to the toilet, while she was eating I would go to the bucket. There was no care for us. We stayed for a long time in prison. Mrs Bani had a pile of pills and insulin injections. She used to inject this insulin herself.

We were then taken to the hospital, to the prison hospital. After a while Mrs Bani was not given treatment until we were transferred to Cell 14 where there were other detainees in that cell, but most of the time we were together and we were very ill. We could not help each other.

In the Cell 14 Mrs Bani was not receiving treatment at the time. After that we were called to the reception, after we arrived at Cell 14, when we arrived at the reception we were told that - it was on the 12th of June, if I am not mistaken of that day, we were told that the state of emergency was not disbanded, we were to continue to be detained.

After that Mrs Bani started to get ill. She asked Mrs Gcina whether we were going home or not. Mrs Gcina said no we are not going home. This disturbed her. Mrs Bani was very sick and she was not receiving treatment in prison at that time.

On the 13th of August Mrs Bani went to hospital alone. She came back on the 15th, the same week. She was very ill at this time. She came back to the cell. I don't know whether to continue about that. I think Mrs Gcina will take over then.

But I remember one night before Mrs Bani passed away it was twelve, midnight, I was taken to the office. Captain Nel was there. He woke me up at that time. When I got to the office I was asked whether I knew Mrs Bani. I said yes. They asked me where I knew her. I said I knew her because we were together in the prison cell. They asked about the injuries, I said she was not injured when she got to prison.

MS GCINA: Thank you Commission. On the 12th of June 1987, as Sheila has already said, we were taken to the reception. We were told that we were going to stay for a longer time in prison because the state of emergency was not disbanded. Mrs Elda was very sick. When she got to our cell she was a confused person. You would give her an apple and she would not take it. She was very ill. She asked me

for how long are we going to stay there. I said Elda we must wait, it might happen that we might die in prison. Anything can happen when you are in the hands of the enemy. We have to wait and we must only pray to God.

On the 13th Elda then became very sick. In the morning we would be asked about our complaints and we complained about the state of health of Elda. We requested for her to get treatment. Captain Nel then agreed. He said that she was going to be taken to a doctor.

When Elda was taken to the doctor we requested someone to accompany her because Elda could not even tell her name. The doctor then did not agree. They said that a person should speak for herself. She was taken to a doctor, she then came back to the cell. We asked for treatment for her. She would be given a chicken thigh, samp with too much salt, there was no special treatment or special diet for her as she was diabetic. They were eating normal food just like us.

Elda then urinated herself. We reported this to Captain Nel because first of all in our cell we were 14. It doesn't matter how small it is but there were supposed to be 14 prisoners in each cell, we could not even sleep in that cell. We then asked for Elda to be taken to an outside doctor because in the cell we had a nurse, Mrs Fazi, she asked for a urine bag for Elda because she was urinating herself.

They took her out of our cell. We found out that they said we were not happy because we were together with Elda. That was Captain Nel and a warder by the name of April, a Black man. We got a report that we complained that we were not happy because Elda was with us.

Elda Bani was taken. After a long time I went to Captain Nel in the office, I asked him where they took Elda he said that she was in Uitenhage in hospital. I asked him whether he was sure, he said yes.

After a few days Elda came back at night together with Captain Nel. Captain Nel opened the cell and we all woke up. We saw Elda, she looked beautiful at that time. She said that the police had beaten her up. She thought that she was just confused because she looked well to us. We gave her food. While she was still eating she urinated herself. Sheila took out her gown and she was naked at that time. She had nothing on except for the pink prison gown. When Sheila took off this gown I saw blood in the left corner of this gown. I said to them Sheila this gown has blood. When Sheila took her we saw that her back was injured. But before this she was not like that. We asked her what happened, she said that the Police had beaten her up. We asked whether she went to the hospital she said she did not know but what she knew

was that she was beaten up.

We washed her and dressed her and gave her our clothes. She slept and the following morning Captain Nel came. I showed Captain Nel that Sheila was beaten up and her gown had blood. Nel said that she must go to the hospital. We said that there should be someone to accompany her to hospital. Nel said that he would accompany her to hospital. After that she was given pills. We asked what for, but nobody told us, but we could see that these were pain tablets.

We tried to talk to ourselves because we wanted her to be treated. Nel said that she was going to be taken to hospital. Elda then left us. I then asked all the detainees to gather in a hall so that we can talk about this matter. We were taken to this hall, all of us, we explained to other detainees that Elda was very ill. When we came back Sheila was called and while we were still in our prison cell we could hear that Sheila was screaming. At the time Sheila was together with Mrs Bani. Mrs Bani could not even speak at that time. We heard that afterwards.

As Sheila has already said they went to Uitenhage hospital. In hospital the doctors said that Sheila you are going to be admitted. Sheila said that I am not sick, this woman is sick she has to be admitted, she was not speaking, she was not saying anything. They came back late and she was taken to a single cell, she was in a coma. Sheila asked Captain Nel that in prison as you said that - why are you keeping me with this person because she is in a coma and she could not speak. Sheila's health then deteriorated also.

Elda urinated herself and I was the one who was doing her washing. At the time, on the day of her death, in the morning I asked Captain Nel if I could wash Elda's clothes. He agreed and he brought me her clothes. But on this day I found out that Elda has vomited. I was very scared, I was confused, I did not know what was happening.

On the previous day Captain Nel came to our prison cell at night. He took Peti Rose Lungu, Namsa September and he left with them. We waited for these two but they did not come back. They came back in the morning. Peti Rose and Namsa September said that something has happened to Elda because they found out that there were men in Captain Nel's office and they asked them whether they knew Elda Bani, whether they knew what was wrong with Elda Bani, they had to answer all those questions. I asked why they left, why they were asking you these questions because they were supposed to ask us, I told them that something happened to Elda. They were scaring them. I could feel that something had happened to

Elda.

In the morning I asked a prison warder for permission to go and see Captain Nel. He told me that Captain Nel was very busy. Sergeant Leech came, together with another policeman, but I've forgotten his name, I think he is preaching, they said that we have tried everything we could for Elda Bani's health but she has passed away. We asked where was she, in hospital or here in prison? They did not answer that question.

But what is important is that I asked to see Captain Nel. I said that we were going to have a prayer on behalf of Elda Bani. We met in one place as the detainees and we prayed for Elda Bani. We were then supposed to report to the township about this. As the detainees of Cell 14 we discussed what to do. I then said that comrades what we must do, when we are writing letters home we must tell these people. When we have a visitor you are going to talk Xhosa and you are going to report this matter to this person. We did this. Fortunately Mrs Fazi had a visitor, her daughter-in-law. We then reported this, and her daughter-in-law reported it to the township of the death of Elda Bani. We reported this to the Black Sash too. We then used the Black warders so they can investigate for us about the funeral arrangements. We called Captain Nel and we requested to have a service for Elda Bani in prison.

MS WILDSCHUT: Sorry, sorry before you go on to the funeral. Could we perhaps just clarify some of the - a bit of the story. While Mrs Bani was in the prison was she already on insulin, was she receiving insulin treatment before she came ...(intervention)

MS GCINA: No they did not give her this treatment.

MS WILDSCHUT: But before she was arrested she was receiving treatment?

MS GCINA: Yes she was. Before she was arrested she was being treated with insulin. She was given this treatment by her doctor outside. When she was arrested she took her treatment to prison and they took this treatment from her.

MS WILDSCHUT: Right. So she didn't receive any medication while she was in prison, no tablets no insulin injections?

MS GCINA: No she did not receive any treatment Honourable Commissioner. As a result we could see that she was just given aspirin.

MS WILDSCHUT: And the request from yourself and Mrs Lesani was that she should get a special diet

and she never got that special diet is that so?

MS GCINA: No she did not get the special diet. We asked Sheila what she was supposed to get. She said that she was only getting a thigh and samp, mealie rice and samp only.

MS WILDSCHUT: When was the first time that she was seen - from the time of her arrest when was the first time that she was seen by any medical person be it a nurse or a doctor or somebody?

MS GCINA: When you are arrested, when you go to prison Commissioner, you would be taken to a doctor as a person who - Sheila was the person who saw her first. I am sure that a doctor examined her because it was the prison policy that when you are arrested you have to go and see a doctor. But I am sure it is Sheila who can say that because they were arrested on the 12th of June. They came to our cell on the 12th and after that she did not receive any treatment.

MS WILDSCHUT: You talked also about the fact that Captain Nel said that he was taking her to hospital, do you believe that she was taken to hospital, because it seems as though you were talking about her being very bruised when she came back from that visit somewhere?

MS GCINA: I didn't believe that she was taken to hospital. What I knew was that she would take her out of our cell to a single cell pretending to take her to hospital. When you are a detainee you would be taken by a prison warder to hospital so we were not aware of whether she was taken to hospital or not.

MS LESANI: I would also like to add something on this matter, the question of whether Bani was receiving treatment or not. When Bani arrived in prison she had her medicine with her. From a single cell, in Cell 2, she was receiving treatment. She was receiving insulin and I was helping her in that. But when we were taken to Cell 14 they said that she was well, she was not given any treatment, she was only given these pills.

MS WILDSCHUT: Thank you very much for your presentation to us today. I don't have any more questions, I will hand over to the Chair.

CHAIRPERSON: We thank you ladies. I am very interested in your story, and I am very pleased for what you have done for us, but I would like to ask my colleagues whether they have any further questions. Wendy?

DR WENDY ORR: Perhaps it's better that you don't answer this question now in terms of the legal

implications, but if you do know the names of any of the doctors whom Elda saw we would be very grateful if you could give those names to us. And I would also like to point out that the doctor in charge of the district surgeoncy in Port Elizabeth at that time was Dr Ivor Lang, who was supposed to take overall responsibility for the health of all detainees and he has in fact been notified that he will be named at this hearing.

CHAIRPERSON: Thank you. Any other? Would you like to add something? Ms Walaza.

MS WALAZA: I think like me I hope that - I am sure that you will all find this story remarkable, remarkable because of the strength of these women to fight the health care for one of their sisters. Remarkable because of the absolute intransigence of the authorities to provide adequate care for Elda Bani. And remarkable because of the way in which the forensic pathologist who conducted the post mortem failed to understand that Elda Bani's pulmonary embolism was most likely a result of being unconscious in a prison cell without adequate nursing care. And lastly remarkable because Elda Bani's death was probably preventable.

If we are to honour the testimony that we have heard today, and if we are to honour the memory of Elda Bani and thousands of other detainees, what steps can we take to ensure that there will never again be a situation where detainees die as a result of medical complicity?

As a group of health professionals committed to human rights we would like to suggest five measures. We ask the TRC to reopen the investigation into the medical care offered to Elda Bani and thousands of other detainees.

We ask the TRC to call upon the professional health organisation to hold their members accountable and possibly levy sanctions against those who participated in the death of Elda Bani, and who were complicit in the detention and torture of thousands of other activists.

We ask the TRC to facilitate reparations to the family of Elda Bani, not only from the President Reparations Fund but from the professional health organisations and their members.

We urge the TRC to recommend to government that the health care of detainees no longer be a matter of custodian care but of health care. That the responsibility be shifted from the Police and Prisons to the Department of Health where it rightly belongs.

And finally we ask the TRC to propose that the statutory council adopt new and forceable codes of

conduct for health professionals working in prisons and police stations so that we can ensure that Elda Bani's death in detention was not in vain. And so that we can restore the honour of the caring profession which failed, not only this woman, but so many detainees and thousands of others.

Thank you.

CHAIRPERSON: Thank you very much. I just want to express again a very deep, deep appreciation to yourselves, but particularly I want to pay a very warm tribute, it is inadequate but it is from the heart, to pay a warm tribute to you, our mothers, for the incredible resilience that you demonstrated. I have said before that the freedom that we gained would almost certainly have been impossible without the quite remarkable contribution of our women folk, and we have had here testimony again of just what wonderful people you and other women who suffered and paid a very, very heavy price.

And I would just hope, I mean that our children and others listening and hearing your story, reading about your story will realise that we have a very precious thing, bought at very, very great cost, this freedom, and that we will cherish it as a precious thing that it is. And for those who sometimes seek to take it for granted it will be salutary for them to know that they are free because of people such as yourselves. Thank you.

MS WALAZA: Thank you Commissioner. Dr Wendy Orr had a question and we did not answer this question, that who was the doctor responsible at this time. What happened in prison was that they were not called by their names. It was a tall doctor, a hefty tall doctor. If I am not mistaken it was Dr Rensburg, I am not sure. But what I knew in prison they were not referred by their appropriate names.

CHAIRPERSON: I think it's probably better to take what Dr Orr said, that we want to be quite certain, we don't want for you to implicate someone when we are not certain. I mean we want to be as certain as possible and not undermine or impugn somebody's integrity when it might not have been that person. You were saying it - thank you.

SUBMISSION ON STEVE BIKO

DR WENDY ORR: It now gives me tremendous honour, and it is with great humility that I welcome Mrs Ntsiki Biko and Mr Kaya Biko, who is Steve Biko's brother, to these hearings. We are indeed most

grateful to have you here, and the Archbishop and I will now come and greet you.

We now ask Professor Peter Folb, who is the head of the Department of Pharmacology at UCT to come forward to give a narrative account of the circumstances surrounding and following the death of Stephen Bantu Biko in detention and Advocate Denzil Potgieter will be facilitating his evidence.

ADV POTGIETER: Good morning Professor!

PROFESSOR FOLB: Good morning.

ADV POTGIETER: Welcome. I would ask you to take the oath first before we listen to your testimony. Could you give us your full names for the record.

PETER IAN FOLB: (duly sworn, states)

ADV POTGIETER: Thank you very much, you may be seated. Professor Folb you are a professor of Pharmacology at the University of Cape Town Medical School, is that correct?

PROFESSOR FOLB: Yes.

ADV POTGIETER: You are also the Chairperson of the South African Medicines Control Council is that correct?

PROFESSOR FOLB: Yes.

ADV POTGIETER: And you are also the Director of the World Health Organisations Collaborating Centre for Drug Policy?

PROFESSOR FOLB: Yes.

ADV POTGIETER: You have come to present testimony on a very well-known case, that of Mr Steve Biko, is that correct?

PROFESSOR FOLB: Yes.

ADV POTGIETER: I am going to ask you to take us through your testimony.

PROFESSOR FOLB: Honourable Commissioners, I am deeply moved to have this opportunity to make the submission to the Truth and Reconciliation Commission in the presence of Mrs Ntsiki Biko, the widow of Steve Biko, and Mr Kaya Biko, his brother.

My sole qualification for doing this is that, at the time, hundreds of students, colleagues, lawyers, clerics, journalists and international experts in ethics and medicine visited me to seek advice or make points and left with me, in the process, more than 2,000 documents relating to the death in detention of

Steve Biko, which are now part of an archive that will form part of the proceedings of the Truth and Reconciliation Commission.

The death in detention of Steve Biko and its aftermath ironically and tragically provided unique insight into what I shall refer.

I shall start by a short excerpt from the inquest into the death of Steve Biko.

> "Mr Kentridge, for the family: In terms of the Hippocratic Oath to which I take it you've subscribed, are not the interests of your patient paramount?
>
> District Surgeon: Yes.
>
> Mr Kentridge: But in this instance they were subordinated to the interests of security? Is that a fair statement?
>
> District Surgeon: Yes. I didn't know that in this particular situation one could override the decisions made by a responsible officer".

Both district surgeons involved in the medical management of Steve Biko in his final days gave the same answer at the inquest.

The narrative account is well-known to many if not all, and I shall repeat it only briefly.

> "On the 19th of August 1997 Steve Biko was placed in detention under Section 6 of the Terrorism Act which allowed him to be held indefinitely.
>
> On the 6th of September he was moved to Security Police Headquarters for interrogation.
>
> On the 7th of September, during and around interrogation he sustained head injury, following which he acted strangely and was uncooperative. He was examined repeatedly by district surgeons and there was external evidence of injury. He was examined by doctors, the doctors, lying on a mat manacled to a metal grille.
>
> A medical certificate, written at the request of the head of the security police was falsified as was the medical record, The Bed Letter.
>
> There was evidence of severe brain injury which was initially disregarded by the doctors. The doctors accepted police refusal of transfer to hospital. The district surgeon described, in the record, the abnormal cerebrospinal fluid which indicated damage to the brain as being normal. After tests showing brain injury the doctors authorised the patient's return

to the police cell.

On the 11th of September the patient collapsed. The doctor accepted police refusal to transfer to hospital and agreed to Mr Biko's transfer 750 miles to Pretoria at the back of a Landrover, on the floor, unaccompanied and without a referring letter.

On the 12th of September, six hours after arrival in Pretoria, Steve Biko died on a stone floor, on cell mats, in Pretoria Central Prison, unaccompanied.

The post mortem examination showed brain damage and necrosis; head trauma - extensive; disseminated intra-vascular coagulopathy as a result of the shock and the assault; failure of the kidneys and external injury to the chest.

The medical treatment was subsequently described by a Judge of the Supreme Court, and by distinguished physicians, on review, as having been callous, lacking any element of compassion, care or humanity".

The inquest proceedings were referred, by the magistrate, to the South African Medical and Dental Council on the grounds that there was a prima facie case, a completely apparent case, against the doctors involved in the case of professional misconduct, and/or negligence in the performance of their duties.

The response of the South African Medical and Dental Council and the Medical Association of South Africa, representing the group interests of South African doctors was as follows:

The South African Medical and Dental Council took two-and-a-half years to respond. In a preliminary inquiry it was found that the doctors had no case to answer, not even the falsification of the medical record or the flagrant disregard of the patient's elementary needs. That decision was ratified, confirmed, by the full Council.

The Medical Association of South Africa, after perfunctory, superficial examination of the ethical issues declared that the South African Medical and Dental Council had been correct in its findings, and that doctors and others who thought differently were politically motivated.

The reversal of the South African Medical and Dental Council decision took years, and was the result of unremitting and determined efforts of Drs Ames, Veriatha(?), Jenkins, Mzimane, Wilson and Tobias.

Was this an aberration in an otherwise proud, if not excellent South African Medical profession, or was it inevitable? The truth is that it was the latter.

It was the culmination, as I have no doubt we shall hear -

- of apartheid discrimination in health facilities and provisions of care at all levels;
- salaries discrimination whereby doctors who were not White earned half of what White doctors did;
- conditions in South African jails and the hostile response, even of the medical profession, to colleagues who attempted to expose these;
- the lack of response to children in detention and their treatment;
- the failure of the medical profession to respond to the banning of colleagues such as Dr Hoffenberg and others;
- the lack of interest of the medical profession in corporal punishment;
- the lack of understanding or training in even the most elementary aspects of medical ethics, and the lack of support and special training of district surgeons and others working in prisons.

There was in this case, as there had been in others, abject acceptance by individual doctors and by their organised profession of interference by the State and by government and by the police in the conduct of their professional activities and their institutions.

Steve Biko was a medical student and under ordinary circumstances he would today have been a practising doctor. His legacy to South African medicine has to be thoroughgoing correction of those issues in this story that might conceivably ever allow it to happen again.

I now wish to, in conclusion, address some personal words to the family of Steve Biko, his widow, brother and children, and to extend to them, as far as I am able, and on behalf of every doctor who feels this way, an apology, to state that this is an auspicious opportunity to do so. And to give you an undertaking that those ethical and human issues, neglected in the case of Steve Biko, will be remembered and continue to be addressed and corrected to the best of our abilities and to express, Mrs Biko and your family, our understanding of how, even until today, you must feel.

Mrs Biko I have composed, for this occasion, a short poem, a haiku which I dedicate to you and the family of Steve. It is my first haiku to have been translated into Xhosa. It reads as follows:

" A sombre duty describing the country's loss before his loved ones".

Thank you.

ADV POTGIETER: Thank you very much Professor. I must say that it is a well-known case but listening to the chronology and the sequence of events it still induces a very deep sense of shock if one listens to what has happened.

Perhaps just to draw your attention to one minor thing, you have started the sequence of events by incorrectly reflecting the date as the 19th of August 1997. I think you obviously meant 1977.

Now perhaps one other issue, even to a non-medical person, the conduct of these doctors in question here, I mean it's clearly unprofessional, at best for them negligent, but it had taken a considerable period of time for the professional bodies to take any action. In fact there has been suggestions that that was part of an attempted cover-up of what happened. Do you have any comment on that issue?

PROFESSOR FOLB: At a meeting held at the University of Cape Town with the Executive Committee of the Faculty of the University on the 27th of September 1980 four members of the Medical Association of South Africa, two of them now deceased, one of them, the President of the Association at the time, advised the Committee that, the University of Cape Town Committee, that MASA, the Medical Association, was under threat from the Department of Health should the Association in any way cast doubt publicly on the competence of the district surgeons and on the health service.

ADV POTGIETER: So it appears as if that influence, undue influence, also played a role it seems in the way in which this thing developed?

PROFESSOR FOLB: That was what was stated to us at the University of Cape Town when we called the Medical Association people to explain why it was that they had given unqualified support to the decision of the Medical Council that there had been no infringement of basic medical responsibility towards the patient.

ADV POTGIETER: And in your view that in itself an extraordinary conclusion by MASA?

PROFESSOR FOLB: My colleagues and I found that extraordinary, and as is known the Supreme Court, in due course, some years later, equally found it extraordinary of the Medical Council.

ADV POTGIETER: Thank you. Professor thank you very much. I don't have any further questions. I will hand back to the Chairperson.

CHAIRPERSON: Thank you very much. Any further questions? Wendy.

DR WENDY ORR: Peter thank you very much, and I'd like to add my voice to yours in apologising to Mrs Biko and her family. Although I am very proud to be a doctor I can never listen to or read the chronology of Steve Biko's death without feeling a deep sense of shame.

And I do hope that one of the products of these hearings is that we will be able to overcome that shame and make sure that that never happens again.

I have had access to Steve Biko's files in the Department of Justice in Pretoria and I'd like to read, just very briefly, from a magistrate's report. It was the law at that stage that detainees had to be visited once a week by a magistrate to record any complaints. On the 2nd of September 1977 Steve Biko was visited by the magistrate and these were his complaints.

> "I ask for water to wash myself with and also soap, a washing cloth and a comb. I want to be allowed to buy food. I live on bread only here. Is it compulsory for me to be naked? I am naked since I came here".

If we achieve anything through this process I do hope that we ensure that human beings are never again treated like animals and like non-people the way Stephen Biko was.

CHAIRPERSON: Pumla.

MS GOBODO-MADIKIZELA: Thank you Chairperson. Thank you Peter. I would like to greet Mrs Ntsiki Biko.

You mentioned in your submission the fact that you thought that the treatment of Steve Biko reflected apartheid discrimination, I think that actually it goes much deeper than that. I think it reflects a total subjugation of the Black body. The way Steve Biko was physically abused was as if he does not feel pain. The way we saw him in the photographs following his death, it was as if he did not feel pain, and one wonders at what point they were going to stop to abuse him. I think that that is the sadness in the relationship between the police and the people that they abused. They had no moral obligation on the people that they abused.

The sad thing about it is that he did not only have physical abuse visited upon him, he also had verbal abuse when, following his death, Kruger declared that he was not moved, his death left him cold. So it's this double violence over someone like him that left the country shocked. I am wondering to what

extent did the treatment of Steve Biko, by the medical profession, set a trend for the way future detainees were treated by doctors?

PROFESSOR FOLB: The point about the death of Steve Biko and the subsequent inquest was, as I have mentioned, that it gave a unique insight into what happened to people. We cannot say how many times that story was repeated, one surmises that it was often.

CHAIRPERSON: Fazel Randera.

DR RANDERA: Peter I know we are going to have submissions from Medical Schools tomorrow but Cape Town is not featuring in that so I am going to take advantage of having you here today, and asking, you've mentioned already that there were hundreds of people who literally came to visit you at the time and subsequently, what changes, if any, did it bring about in the human rights and ethical teaching that took place at the University that you were present at?

PROFESSOR FOLB: The Universities, including our own, started from the position at that time of not teaching the students anything about ethics and their responsibilities to people such as prisoners, detainees, their rights and obligations with respect to the police and to the State and to interference by the State and the police. Insofar as that was the position there has been improvement since then.

CHAIRPERSON: Thank you very much. I just want to say that whilst there is the horror that is evoked by hearing yet again what did take place, I want us also to take account of the stand that was made by people such as yourselves and others, and that we are this extraordinary mixture in this country, and the wonder is that the good has managed to prevail.

Whilst we mustn't engage in a great deal of self-congratulation I think it is a good thing to say yes, there was evil, there was all that was wrong, but that was not the only element in the story, and that it would be people like yourself and others of the same ilk who will help to ensure that we do get the kind of South Africa where this sort of thing doesn't happen again. That now your Medical Schools will have said that an important part of your syllabus is inculcating the culture of a respect for human rights and I am sure that that is happening, but that we need a great deal more than ever before, especially with a democracy that is still so fresh, we need those who will speak out when it is necessary to do so. And that we mustn't allow ourselves to be fobbed off with accusations of, oh you are being a racist or whatever, that we've got to say that we want to be able to stand upright and hold our heads high in this country, and want

to know that those who are the custodians of this kind of thing are people who will in fact stand up and be ready to be counted and speak the truth without fear or favour. I salute you and your colleagues. Thank you.

DR WENDY ORR: While the Archbishop is greeting Professor Folb I just want to show you the number of messages of support we've received from around the world and I am going to try and read some of them over the next few days.

The first and perhaps the most important is from President Mandela himself. He sends his best wishes for the success and positive outcome of the hearings.

We have one from the Department of Psychology at the Orange Free State saying,

> "We sincerely hope that your efforts will succeed in healing this wounded and ailing community of ours".

And one from the Psychology Department at Potchefstroom University which says,

> "May the hearings related to Health Sector involvement in past human rights violations be a constructive process of facilitating structural and individual healing, increased affirmation of human rights in service delivery and a vigorous commitment to enhance the quality of health care".

We will hear more messages as the days proceed.

SUBMISSION BY MILITARY MEDIC

DR WENDY ORR: I now call Sean Callaghan to give evidence. Sean thank you for being here, I know you have travelled all the way from Durban to be with us today. You and I have spoken before. This really is your story and I admire you tremendously for your courage in coming forward to tell it. You were a conscript in the South African Defence Force in 1982 and 1983 and served as a medic. Before you give your evidence I am going to ask you to take the oath or the affirmation, which would you prefer?

SEAN MARK CALLAGHAN: (sworn states)

DR WENDY ORR: Sean please go ahead and tell us your story in your own words.

MR S CALLAGHAN: I am glad that you made a slip because at least it calmed my nerves slightly.

I want to really touch on two main issues today. Firstly my experience as a medic in the South African Defence Force, and secondly my struggle against post-traumatic stress for the ten years after that.

I was 15 years old in Standard 9 when I was asked to sign all the papers for military conscription, and part of the questions which I had to fill in was which unit would you like to serve in and why would you like to serve there? I put down that I would like to be a medic, and my reasoning was I would like to help people rather than kill them. That was the motivation from which really most of my life was going and from which in January 1982 I got on a train for Potchefstroom.

I spent three months in Potchefstroom learning how to march in a straight line, learning how to

shoot at the target and things like that.

I was then sent to Pretoria for a further six months of training to become an operational medic. During that time I learnt as much as I could about pharmacology, about trauma, about casualty, about nursing, everything from how to make a bed with square corners through to what do you do when a patient had a rocket through the middle of their chest.

During that time, the first time I ever put a stitch into a person, or the first time I ever gave anybody an injection was at Tembisa Hospital. As medics we were sent there on Friday and Saturday evenings to practice on people because quite frankly it didn't matter if we made a mistake because they were Black people, and many mistakes were made. Certainly we weren't asked to practice at 1 Military Hospital. At 1 Military Hospital we learnt how to make beds and how to give pills to people and things like that.

The first time I ever put a drip up successfully was actually in Angola when I was confronted with a patient because up until then I was too scared to practice on my friends because they would have to practice on me.

In essence after nine months of training and really six months of medical training I was posted to Oshakati in Northern Namibia where I worked at the Oshakati Hospital which at that stage was the main casualty evacuation hospital. I spent 13 months in South West Africa and Angola as a medic.

All of us who left Pretoria went through Grootfontein and there we were divided amongst the various units, amongst the various hospitals. Some of the people who went with us were sent straight to Unita, to be medics for Unita, particularly one chap who used to sleep in the bed next to me in Pretoria, and when we all came back 13 months later he didn't come back and I still to this day wonder what happened to him.

Nobody in my family has ever died. All my grandparents are still there. My parents are still there, my brothers, sisters, my cousins. I've never been to a funeral. In fact I've been to a colleagues funeral subsequent to going to the army. I've never seen a dead person until I was in the army.

My first night in Oshakati I was supposed to go on duty and happened to be at a music concert which had come to town, and heard helicopters come over and from the stage they said any medical personnel please go back to the hospital, which I ignored, and a few minutes later, anybody with B-negative blood please go back to the hospital, and being a medic and having B-negative blood I thought

well now I've been called twice I had better go back, to be confronted with a patient who had no arms and no legs, was blind and was deaf, who had been in a mortar pit launching 80mm mortars when one of them exploded in the pipe, that was the first patient I ever saw in the operational area.

Right there and then I realised that as an 18 year-old I am not going to be able to handle this after six months of training, and right there and then I decided that the only way to cope with the situation was to switch off my emotions immediately, not to feel anything for anybody, not to try and fit into any kind of humane circumstance but just to be a cold machine that did what I was trained to do.

Most of the patients that came through Oshakati Hospital were Black. Most of them were 32 Battalion. Most of them came out of Angola. I would say that on average there probably were ten patients that were very seriously injured that were flown in every day. One or two of those dying every day. If you look at the official statistics you will see that the Angolan/Namibian war cost South Africa 250 odd people which flies right in the face of what I saw. And when I asked who are those 250 odd people they were White national servicemen. We never counted, seemingly, any of the mercenary troops, any of the Black troops, again because they weren't really there, and they weren't really official.

There were 10 to 20 medics at that Oshakati Hospital, maybe four doctors, one surgeon, one anaesthetist. The surgeons and anaesthetists used to come in on a weekly or two-weekly basis. We had two theatres and it was pretty much get in and do what you could. If you had 20 patients come in from a landmine explosion there weren't enough of you, and there certainly weren't enough doctors or surgeons to go around and it was a matter of get in and do your thing and hope for the best that you are actually going to be able to save some of these patients. Doctors became surgeons and anaesthetists, medics became doctors. Schedule 7 drugs were, well we think this will work so let's put it in and hope for the best. I must say that I think we did pretty well for the little group that we were, but we could have done a lot better if we had had more personnel.

During December/January 1982 I had been in the operational area now for three/four months and many people had been there for many, many more months. Again I would guess that there must have been about ten suicides that I heard about in the operational area during that Christmas time, national servicemen who couldn't take it. They were away from their loved ones, and they in a sense couldn't take the pressure and they shot themselves.

In January or February 1983 I was posted to Onjiva which is maybe 50 kilometres inside Angola. It was a 32 Battalion and Unita base at the time. I specifically remember going there because I specifically remember Pik Botha saying on television that we weren't in Angola at the time and there I was.

One of the operations which was being run out of that base was the resident doctor ran a little clinic under a tree outside the base for the local population and we did everything from give-away vitamin pills and aspirin for toothache, through to anything that we could possibly try and treat. The Military had a term for it, it was called COMOPS, Community Operations, basically trying to win hearts and minds, make them feel like we were the good guys.

While we were there the International Red Cross, who were based in the town of Onjiva brought a woman to us who had breast cancer and asked us if there was any way that we could possibly arrange for her transport to South Africa for treatment. When the doctor and I took this back to the base commander we were severely reprimanded because we had spoken to the Red Cross, because quite frankly we weren't in Angola so how could we be there to talk to them. Any acknowledgment of our presence would have meant an acknowledgement of troops being there and therefore any treatment for this woman would have meant that the only way we could have treated her was if we were actually there.

Another one of the patients who came into the base while I was in Onjiva was a young White South African conscript who shot himself in the foot while on guard duty in an attempt to get out, and that was quite a good way of getting out because he couldn't walk around and fight anymore, so he was obviously sent home. I am not sure whether his foot was saved but it was, in his mind, better than being there. At that stage there was no doctor in the base, there was me and me alone. I treated him with as much morphine as I could possibly get into his body every few hours and flew him out the next morning.

A few days later the new doctor arrived and as he arrived I got a message to say that a number of 32 Battalion members had been involved in quite a serious contact and that the helicopter that dropped him off would be going straight on to pick up those patients and were coming back to pick us up to fly us back to Oshakati with these patients. We identified blood groups and drew as much blood as we possibly could from the people in the base. I essentially told the doctor, put your kit down and get ready we are getting back on the helicopter.

We were presented with two patients, one who had shrapnel wounds covering his body and cer-

tainly looked like the worse off of the two. Another complained of chest pain in his lower right chest and had lacerations on the top of his left shoulder. It was pretty obvious that he had internal bleeding within his chest cavity and we put in a chest drain and he pumped out 1.5 litres of blood and we thought okay, probably what we have done is chopped open an artery and let's hope like hell that he actually survives the airplane flight. What we didn't realise is that he had a live rifle grenade stuck in his chest. It was an anti-tank grenade which had flown through the air and hit him in the top of his shoulder and lodged against the ribs, at the bottom of his chest, and 30cms of bomb were sitting inside of him. We happily unloaded him at Oshakati and when they took him into X-rays they immediately cleared out the hospital and the operating theatre and brought in the bomb squad to actually remove the bomb out of the man's chest.

Later in February I went back to Oshakati and back to the Hospital and one Wednesday evening a helicopter came in with four patients who had been in a Buffel that had driven over a double landmine. The landmine had blown a core through the middle of the diesel tanks of the Buffel and sprayed burning diesel all over the people inside. Those that came to us, the four that came to us were essentially 90% third degree burns and I landed up treating one of the patients, giving him a mixture of valium and morphine, dressing his wounds ready to send him to Pretoria, and he was still conscious and he pulled out of his pocket a photograph of his girlfriend and he said to me I'm really glad I've been injured because I'm going to go home and I'm going to see her. I didn't know what to say to him because I knew that he wasn't going to actually live through the night. He wasn't going to get on the airplane, and yet nothing had prepared me to counsel him, to talk him through that, and I just said, that's great, she's very pretty. That night I took off my clothes, which at that stage smelt like burnt flesh, and threw them in the corner of my room, and the next morning went through to Ondangwa Air Force Base where the remains of the other six people who were in the Buffel were brought in. Essentially there were about 20 pieces on the table. Nobody knew which piece fitted with which piece, which piece belonged to which name, and most of the pieces were contorted from the heat. They were burnt black to the bone. Eventually all we did we put the pieces into six body bags and put them into coffins and put big labels on to say don't let the parents have a look at this and sent them back to South Africa.

That night again I threw my clothes in the corner of the room and the next evening I started having nightmares about that incident. My room stank like burnt flesh for weeks afterwards. The only way that

I dealt with the nightmares was that I just didn't sleep for about three days and then they seemed to go away.

While I was also at Oshakati we had at least one SWAPO patient who was chained to his bed. The thing that surprised me about him was how dignified and intelligent he was, because I was taught that he would be this uncouth animal. He spoke Afrikaans, he read Huisgenoot, he asked me where I came from, I told him a small town in the Eastern Cape and he said Port Elizabeth or East London? He obviously knew a lot more about my situation than I knew about his.

While at Oshakati there were a number of gay medics who would sexually harass patients and which many of us knew about but there was absolutely nothing we could do about it.

Having been there for six months four of us were asked to go and join Koevoet, to be medical personnel to Koevoet. All we knew about Koevoet was they were the guys who didn't strap themselves into casspirs where the rest of us had to. They were the people who drove down the middle of the road, even if there was a landmine there, not through the middle of the trees and bushes, and they were the guys who drank beers while sitting on top of casspirs instead of drinking water while on patrol. And in a sense that was something which was quite attractive to 18 year-old boys who were living under military rules and military regime.

We cashed in our browns for camouflage uniforms, we let our hair grow long and four us went and worked with Koevoet for a further seven months.

I was seconded to the Koevoet team Zulu India led by Marius, I cannot remember his surname, and second in command John Deegan, with probably about 50 Black, many ex-SWAPO combatants with us. I stayed at the base, Onamwandi, which was next door to the main Koevoet base which was a prisoner of war camp, for those prisoners which Koevoet members caught.

The procedure at the camp was that those who were captured were brought back to solitary confinement until they were prepared to sign application forms to join the South African Police or the South West African Police which immediately mean that they weren't prisoners of war anymore and therefore the Red Cross couldn't touch them. There must have been a couple of hundred prisoners of war who stayed in that camp while I was there, and one of the big questions that still remains in my mind is what happened to those people when we pulled out of Namibia, because certainly we wouldn't have declared

them. My gut feeling is that when Koevoet broke the UN ceasefire in 1989 that that was a good time to assassinate all of those prisoners of war.

Koevoet worked on a bounty policy where anything and everything that you brought in had a price on its head. People somewhere around R2,000, large calibre mortars probably a bit more, landmines slightly less and so on, which was a great motivating factor for the combatants and the teams because you could earn double, triple your money. It also meant that score boards were kept and that the teams competed against each other for the most number of kills in a given week in the bush.

During this time I went home on leave probably for the first time since I had left Pretoria. I had long scruffy hair, I had a scruffy beard, I wore camouflage uniforms and when I arrived at Port Elizabeth airport my mother ran away from me because she couldn't believe what she saw.

While I was on leave my unit, Zulu India, was involved in an ambush and the casspir which I would have been in, and the place where I would have been sitting, my replacement had his legs blown off.

I had applied for Medical School and Wits had offered me, well had got me as far as interviews and I went for an interview with Wits Medical School during this leave and said to them I don't want to be a doctor anymore, not after what I've seen. I went off and applied for Computer Science at the University of Port Elizabeth.

While at Koevoet I was involved in clashes with SWAPO, probably every week that I was in the bush. One of the first ones was a situation where we were driving down the tar road back to Oshakati and a number of SWAPO personnel were drinking at a shebeen on the side of the road and we turned off, it was just dusk, we turned off straight, driving straight towards them and one of them managed to shoot a rocket grenade right into the middle of our engine and we were stuck in the middle of this clearing. I remember pushing my rifle out of the gun port and pulling the trigger not knowing what I was shooting at and not knowing what was happening for the next five or so minutes. There were just loud bangs, flashes of lighters, rockets flew by as anyone and everyone shot anything that they could out of the holes in the casspir.

At the end of it I realised that I hadn't shot a single shot because my rifle had jammed right there and then. I was so angry that somebody had tried to kill me, the fact that I had been part of a team that tried

to kill them hadn't really entered my mind, and I stood up on top of the casspir and there was one insurgent who had died in that conflict and I shot his dead body, in a sense to get rid of the anger within me.

Later that night I had diarrhoea, I was vomiting, I just had a complete physical reaction to that whole situation and everybody laughed at me, everybody in the team, they said don't worry it happened to all of us the first time, but you'll get used to it. From then on I carried an AK47 not an R1 because I knew that maybe it wouldn't jam the next time.

Another incident which I specifically remember while with Koevoet was two SWAPO members who were captured at the beginning of the week that we were in the bush and they were interrogated, they were shocked with telephone winders on their genitals in order to get as much information out of them as possible. The unit commander used torture to get information so that we could find other SWAPO members, so that we could find other arms caches, because all of that meant money.

At the end of the week they were told to dig graves and they were shot and left in those graves. I always wondered why they weren't just taken in, but maybe it was because they were shot at point-blank range and somebody would have noticed.

Every time there was a contact bodies were tied to the casspirs' bumpers, to the mudguards, to the spare wheels and we drove around for a week maybe with those bodies tied there, through dense bush, the skin being ripped off of those bodies. Really, for two reasons, one, it intimidated anybody and everybody that saw us, and two, those bodies represented money and those faces represented a command structure that was being put together in the prisoner of war camp, and those bodies were shown to prisoners of war to say who was this, where did he fit into the structure.

Once we picked up a spoor and chased a political commissar for two days. We chased him relentlessly towards the tar road knowing that if he managed to get to the tar road before us he would probably be able to avoid us and we would probably lose the track. There were 50 of us in casspirs with canons and rifles and enough ammunition that five casspirs can carry, and food, chasing one person running with an AK47. That was pretty normal for Koevoet, they did that all the time.

Eventually we did catch up with him two days later. He was hiding in a kraal. My unit commander, second in command, because the unit commander was on leave, John Deegan chased everybody out of that kraal and of course he stayed hiding in the hut. He lined up a bunch of Koevoet members on the

one side of the hut and drove over the hut with a casspir. Everybody then fired into the rubble and they pulled out the political commissar who was then handed over to me, as the medic, to treat. He had been shot in the arms and the legs. He'd been ridden over by a casspir. I immediately started applying bandages, putting up a drip. At the same time John Deegan was interrogating him, because as a political commissar he would have been carrying a handgun. His handgun couldn't be found and I guess that John wanted it for his personal collection. While putting up a drip John got so frustrated that eventually he shot the patient while I was working on him, through the head. That patient was just then somebody who got tied to the bumper of the casspir.

I've met up with John earlier this year to try and understand why he did that and how that affected him. I went to visit him in Johannesburg. He still wears camouflage uniforms, the room where he was living was covered with camouflage netting, he's dropped out of society, he's on drugs, he's an alcoholic and he tells me that it was all because of that day and what he did, and that he completely lost it, and that 15 years later he's still carrying that incident with him.

A couple of weeks later I was at the Koevoet base and was called into the detention cells where I was presented with a patient who had been tortured by pouring boiling water over his chest and genitals and he had welts and burns all down his front. I was completely incompetent and unable to treat him and went and called a doctor from the local hospital. And essentially was told you don't tell anybody about this, this never happened, he wasn't a SWAPO member, he was just a member of the public, but we made a mistake. Make him go away in a sense. I don't have any idea what happened to him because I handed him over to the doctor.

While I was still at - my last month or so there, one of the Koevoet unit commanders was killed in a road accident. Basically the rest of the White Koevoet police members went on a complete rampage. They threw handgrenades at each other. They fired AK47's. They essentially demolished their whole base camp over the death of one of their members. Again, as I look back at that I start to understand the trauma that they were going through because of the things that they were doing. As medics we had unlimited access to schedule 7 drugs. We were given ampules of morphine, Sosegon(?), and if you are on patrol and if you drop an ampoule of morphine you didn't have to account for it as much as if you were in base camp and opened an ampoule of morphine and injected it into yourself, you didn't have to account

for it. And in a sense many of my friends were either complete alcoholics or abuses of schedule 7.

I remember sitting up one night waiting for a friend of mine to die because he had injected himself with a mixture of two ampules of morphine and an ampoule of valium directly into his arm. He didn't die but I certainly thought he was going to die.

Around that same time I remember phoning my mother and telling her that I wasn't sure if we were going to actually survive the night because we had got to the point of being completely suicidal. We had come to the end of our tether. We had been involved in that kind of thing, seeing patients, seeing people being killed for 12 months already and all because I wanted to go and heal people and not kill them. And we went to go and see the local psychiatrist who was resident in Oshakati and the Major in charge of South African Medical Services up there, and we were basically told to grow up and carry on and there was nothing wrong with us. Eventually we did get out.

A bunch of new recruits arrived. I happened to recognise one of them from school, got him and three of his friends, I said you are not going there and the four of us got on the same plane and left town, and a week or so later we arrived back in Pretoria with everybody else. That was November 1983.

In theory we should have had 50 odd days leave due to us because we were promised one day of leave for every weekend that we spent in the operational area, and with only 20 something days left until the end of our military service we all expected to go home. Instead we stayed in Pretoria, had no leave and built a bar for the officers. There was no de-briefing, there was no "what happened to you"? There was no, "this is what you can expect when you go home"; "this is how you should try and integrate yourself back into society".

I do remember a letter, I think being sent to our parents, with 10 points on it saying something like, you had better lock your alcohol and your young girls away because these young boys are coming back home. But that was the extent of the support that we got.

I went home and I had heard about things like "bossies" and so on, not understanding what it was. I was hyper-vigilant. I was having screaming nightmares every night for at least six months. I was very anti-establishment, anti-social, I was cold. Whenever I heard a loud noise I would dive to the ground. When I heard helicopters I would look for somewhere to hide. I used to wear camouflage uniforms because I had brought a whole box of memorabilia home with me and every time I went hiking with some

friends in the Wilderness I would put on my camouflage uniforms. I remember going to see a film with my father and a helicopter came flying over in the film and a gunshot went off and I dived under the theatre seats.

Eventually I learnt the avoidance tactics. Eventually I learnt that I don't go and see these kind of films, I make sure that I don't go into those kind of places, I learnt how to cope with what I later became to understand it was post-traumatic distress order.

In 1989 I had quite a good breakthrough, which was seven years after being in Angola, and I made a bonfire in the back garden and took all that memorabilia and burnt it and marched around and sang songs and my parents and my sister were crying thinking that I had gone completely mad having watched me deal with this unknown thing for seven years and then seeing this. That brought some relief.

And then at the end of 1990, the beginning of 1991 the Gulf War started and CNN carried the feed for 24 hours a day and I happened to live in an area of Johannesburg at that time where I was able to receive CNN feed and got completely addicted to CNN, completely addicted to the Gulf War. And once again all the nightmares came back, but by this stage they had been distorted completely out of reality. The recurring nightmare at that stage was a swimming pool full of blood and helicopters landing in the back garden and me carrying patients from the helicopter in my bedroom to treat them. Waking my house mates up night after night with this nightmare.

I eventually, during the Easter of '91, went to go and seek psychiatric help from a private psychiatrist who immediately diagnosed me with post-traumatic stress disorder. I couldn't afford to see a psychiatrist so he made a plan for me to go and receive treatment at 1 Military Hospital.

I was there over the period of Easter '91 and during that time I saw a psychiatrist for about three hours in about ten days, at the end of which he declared me fit for battle and sent me home and that there was nothing wrong with me. The point was that I wasn't fit to be a father and I wasn't fit to be a husband, but I was certainly fit to pull the trigger of a gun.

For the rest of '91 and '92 I had to seek out my own counselling. I had to go to friends, I had to go to church, I had to go to anybody that could help me. By '94 I was offered an opportunity to go back to Oshakati by a journalist who would write a story about me and I turned her down purely because I couldn't face the ghosts that still lived there.

In '91, '92 I remember going to see the film, "For the Boys", by Bette Midler and I remember coming home crying and not wanting to sleep all night again because of the nightmares. And that was after my treatment and after my counselling.

Essentially I think I am pretty healed. I think I have come to a point of being whole. I have my emotions back. I am a father. I am a husband and I can do those things pretty well, but no thanks to the SANDF or the SADF for helping me.

I think as a last point the question remains in my mind, what can the Commission do for other people like me? Every South African family, be they Black or White, has been involved in a conflict, and if statistics are anything to go by that means that there are a few million of me walking around who haven't dealt with their post-traumatic stress. I don't know how the Commission can help set up some kind of counselling for those people, but if the Commission can't I don't know if anybody can. And I am not sure that many of them would even be willing to come to the Commission or to counselling purely because they are South African men and we don't cry.

And secondly, I think maybe we can take a lesson from the vets of Vietnam. Maybe we need to build some kind of a memorial where we can go and have our time of mourning. Some place where maybe the names that you are collating as a Commission of everybody who has died in this conflict, from all sides, are put up on that wall, so that all of us can go together and touch something, something tangible that says it's over, and something that says it was this big, and something that says it was important enough for us to be healed from it.

DR WENDY ORR: Sean thank you very much. You have shared with us a story of multiple abuses, a young boy really being sent into a situation which he wasn't prepared for; being faced with the most horrendous pain, suffering, injuries; being forced to carry arms when in fact you were someone who wanted to heal and not to kill. And finally the lack of acknowledgement of the pain and trauma that you went through. And I know you have travelled a very, very long journey since 1983 to come here today, and I want to say thank you very much for sharing this with us.

I hand you over to the Chair.

CHAIRPERSON: Thank you. Pumla Gobodo.

MS GOBODO-MADIKIZELA: Thank you God and thank you Sean. I think your experiences you've

shared with us are a very painful example of the incredible suffering that young White men are carrying around themselves in this country. Unfortunately it's very much an untold story. No-one knows about the suffering you and people like yourselves have gone through because of the symbol of the South African Defence Force in those years. Unfortunately the country looks at those people as people who were fighting on the side of apartheid without realising what you had to go through to put yourselves in a situation that you were forced to be in.

I was listening to you as you were recounting the changes that you went through. You went in, you wanted to prevent death and to protect life, and you were confronted with the reality of the situation where in fact you had to be faced with death and brutal death for that matter, and you had to switch off your emotions.

Now I wonder if you could tell us a little bit about this strategy of switching off? I imagine that it was in the interests of the army officials that many of you switched-off, how did the army encourage this switching-off?

MR S CALLAGHAN: The military training which every White South African who was conscripted went through essentially was designed to break the individual and make them part of a whole, to break any individual spirit and to make you part of a unit, which in a sense is understandable in one point of view from a war perspective, but not acceptable from a human perspective. I think the simple lack of acknowledgement, the simple lack of any support, any acknowledgement that seeing that first patient might have been traumatic for me, or seeing those kinds of patients every day might have been abnormal; the simple lack of any kind of focus groups or any kind of support groups or anything when we came home, any material, that in itself constituted a strategy which de-humanised us in a sense.

I don't specifically remember saying to myself one day I've got to stop feeling about these things. All I know is that as I look back I got to the point where I had to cope with the situation I was in and the only way to cope was to feel nothing. The problem really became, once I was out of that situation I still felt nothing, I didn't know how to express any positive emotion. I didn't know how to love or how to be happy, or how to experience joy or any of - the only, in fact even an emotion like anger I didn't know how to direct it other than through a violent reaction to it. And that is really what took me 10 years, 15 years to undo, was that searing which took place in a sense.

MS GOBODO-MADIKIZELA: Sean I am going to ask you a little bit about what happened in Tembisa. Thank you for that explanation.

When you went into Tembisa Hospital as medics, what kind of official arrangements were there for you?

In other words was the superintendent aware that you were not doctors?

Was there a standing policy about medics, military medics coming to practice on patients? Can you tell us a little bit about that.

MR S CALLAGHAN: It was a standing procedure I would guess that often Wednesday nights, Friday nights, Saturday nights, medics in training went to both Tembisa Hospital and the hospital at Attridgeville. It was an accepted norm. There was no, what are you doing here? Why are you here?

The doctors were very obviously briefed to train us, to help us, to help us understand how you inject a wound before you stitch, how you stitch these kinds of wounds, how you inject, where you inject, why you inject, those kind of things. We learnt "on the job training" in a sense.

We worked together with civilian doctors, civilian nurses who worked in those institutions. We were catered for at lunch times or at supper times in the canteen. We were part of the establishment.

MS GOBODO-MADIKIZELA: Thank you Sean.

CHAIRPERSON: Thank you very much. I can only say that one is so very aware, listening to your testimony, to the high price that has had to be paid especially by our young people to get us where we have got to. And I hope that we might be able to encourage the faith communities to take, as a particular part of their share of this healing, the sort-of credicur(?) that you were expressing in that people came back and did not have the facilities. I hope that as people read about and hear testimony such as yours that it will urge, especially the faith communities, to take this up as a very serious task.

But we must keep remembering that casualties were on all sides, and that the healing, if it is going to happen, is a healing that must embrace all of us in this traumatised, this deeply wounded people. And sometimes they speak of the wounded healers, that those of you who have been through and come through the other side might also be able to assist your comrades and help them perhaps to come through to the point which you have reached.

But we want to thank you for your courage in coming forward and enabling us to tell as full a story

as possible, be able to give as full, as complete a picture as possible of the human rights violations that have happened. And that people walking the streets of our cities and our villages look whole and perhaps not very many of us are whole.

Thank you.

MANIPULATION OF FORENSIC EVIDENCE

DR WENDY ORR: We are now going to move on to Dr David Klatzow's evidence because two of our colleagues have had to leave for a meeting with the Department of Justice, so we will return to the witnesses whose evidence they will facilitate after lunch. Dr Klatzow will you please come up to the table. Advocate Denzil Potgieter is going to facilitate your evidence.

ADV POTGIETER: Thank you Wendy.

ADV VAN ZYL: Advocate Potgieter may I at this stage please intervene with your permission. My name is Van Zyl, I appear on behalf of certain clients, including General Lothar Neethling. As I understand the notice that had been given to him in terms of Section 30 of the Act his name, or he himself might be implicated during the evidence of Dr Klatzow. If not so, if you indicate to the contrary then I will accept that, if not, then I am unfortunately then in a position that I have to then raise certain matters with you. If he's not going to be implicated by this witness then of course this issue is settled.

ADV POTGIETER: Yes thank you Mr van Zyl. I am told that Dr Klatzow won't be referring to any individuals in his testimony.

ADV VAN ZYL: Thank you.

ADV POTGIETER: Thank you. Okay.

CHAIRPERSON: You have no objection!! (General laughter)

ADV POTGIETER: Thank you. Dr Klatzow I am going to ask you just to take the oath. Your full names for the record.

DAVID JOSEPH KLATZOW: (sworn states)

ADV POTGIETER: Thank you. Please be seated. You will in your testimony give an account of your personal experience as a forensic scientist and you will also be referring to some cases which illustrate the way in which forensic science has failed in its professional duty to serve the community as you indicate. I am going to ask you to please just proceed and present that testimony to us, Dr Klatzow.

DR KLATZOW: Mr Commissioner, thank you for the opportunity of allowing me to address the Commission. It has been a deeply humbling experience to hear this morning the testimony of others who have clearly suffered far more than I have suffered, which is not at all. The work which I have done seems so minimal in relation to what I hear before me this morning.

But in a small way I would like to make this offering to show you what was done and in a way, almost as a cathartic experience for myself to get rid of some of the anger of the things that have happened in the past and which I may well not have done enough to prevent their happening.

This submission has been the end process of a great deal of thought, extending over many years and after much consideration I have decided to mention the broad topics and to avoid the mention of names. I don't have to expand on the fact that the mentioning of names has created, or the thought that there might have been mentioning of names, has created a great deal of agitation, as was evidenced by that worthy gentleman's submission a few seconds before I gave evidence. But the persons and people that I will be referring to, in any event, know just who they are. And as the purpose of this Commission and this hearing is above all reconciliation I cannot see any good that will come out of the names being mentioned. They will, in any event, give rise to a welter of accusations, denials and counter-accusations would, in my view, obscure the true point of my submission.

This is, in essence, to make the community at large and the legislators aware, and as much as I can do in my small part, of the way in which forensic science failed the community that it was bounden to serve, and how these failures resulted in the eventual support of the evils of the system which are now coming to the public attention, largely as a result of the efforts of the TRC.

It should be explained that forensic science is the parent discipline and may be divided into a number of sub-specialities, forensic medicine being one of these, as are blood grouping, forensic blood grouping, serology, DNA testing, ballistics, fire investigation and a host of other specialities. And they have in common, all of them, one thing, they are all subject to the laws of science and these laws are flouted at some considerable peril, as I can give evidence on from bitter personal experience.

It's impossible to separate out the different categories of forensic science into watertight compartments as they all function together in the judicial system, and the inter-linkages were so intimate as to make the task of separating them both unfruitful and illogical.

A forensic post mortem would have several of the other specialities involved in it, and for instance there was no point in taking a bullet out of a deceased unless it was subjected to other forensic tests, and the whole system was coordinated to form a coherent end point.

In each category, and my submission is about forensic science in general, including forensic medicine, in each category the system failed to deliver an impartial service to the community. Each part of the system became so integrally part of the police, and they in turn were such an integral part of the system of repression that eventually the whole forensic science service came to be part of that repressive and shameful system that was apartheid.

I would like to illustrate from cases in which I have been personally involved just some of the points made so far.

When I first went into practice in 1984 I spent some time attempting to get the State to alter the way in which blood was taken for the analysis of blood alcohol, and after some correspondence with the Deputy Attorney General in Johannesburg, and a string of acquittals the system was changed to that which I had advised all along. The nett effect of all of this was to make me a set of extraordinary vituperative enemies in the forensic science service countrywide.

I vividly remember one of the pathologists from the State Mortuary in Johannesburg relaying the comments of a senior member of that laboratory after he, the pathologist, had been observed in conversation with me. "Don't" said the senior man, "speak to that bastard, the State are gunning for him". That's as it was to be for some time.

I failed to see the reason for this attitude, but even more so I failed to see and understand why that senior man, who made that comment, failed to recuse himself from a matter in which I was giving evidence and in which he was sitting as an assessor.

In addition that same man, vigorously over the years, opposed any efforts on my part, ever, to obtain first-hand evidence from any post mortems that were done under his control in various fields of interest to me. And if there was ballistic evidence to be had I was excluded on the grounds that I was not medically qualified, and that only medically qualified people were allowed to attend medico-legal post mortems. There were many others who attended post mortems at this time who were not registered with the Medical and Dental Council.

And the failure of the State pathologists to allow the family proper representation and proper expert assistance for the pathologists who did get into the post mortems on behalf of the family always put the deceased's family at a disadvantage and made the work for the family representatives very difficult indeed.

An example of this was during the middle eighties when in Natal a police constable was shot dead by his colleagues under very questionable circumstances. The State pathologist who was in charge of the post mortem simply refused me access to the post mortem and went out of his way to hinder the appointment of a pathologist for the family. At the time he was unwilling to delay his post mortem to allow for the travel arrangements of the family pathologist, and every possible obstacle was put in my way, to the point where the State pathologist made insulting and derogatory comments about the experience of the family pathologist.

By the time that we eventually got representation at the post mortem, by the time the post mortem was done, and by the time we could get our pathologist in at the same time as it were, but it was later in the day, the car had been hosed down, in which the shooting had taken place, and vital evidence appeared to have been destroyed forever.

During the Ashley Kriel inquest one of the State pathologists sat on the bench as an assessor and this particular individual had occupied a chair in forensic medicine at one of our universities and thus I would have expected him to have more than a nodding acquaintance with research methodology and experimental design, and this was not shown to be the case in the subsequent enquiry.

The facts, as I am sure you will well know, are briefly as follows. Informers had led the police to a house where Ashley Kriel was staying, and when an arrest was attempted Kriel allegedly produced a pistol and during the scuffle he got shot in the back with his own pistol and died on the spot.

It became crucial to estimate the distance between the muzzle of the weapon and the body at the time of discharge. Kriel was wearing a tracksuit top and a T-shirt, and the bullet traversed both sets of clothing to inflict a fatal wound in the heart. There were certain stigmata on the body which suggested that the wound was a close-contact shot and thus supported the police version.

However, the hole in Kriel's clothing through which the bullet had passed was small, it was indeed calibre size, and this was inexplicable because when a weapon is placed up against clothing and dis-

charged under the conditions that were described it invariably tore a large rent in the clothing as a result of the hot gases which emanate from the muzzle of the weapon. The hole in Kriel's clothing clearly did not fit this, and was extremely perturbing to me. The State were also clearly perturbed by the findings and sent their ballistics expert to perform exhaustive tests, 200 shots were fired.

The exact words used by this expert at the inquest are reproduced here because they give much more meaning and substance to my views than anything that I could say. I want to quote from page 171 of the transcript of the inquest and the syntax is not mine.

> "Your Honour, the purpose was to make sure that I am correct".

What a wonderfully directed way to start your experiment.

The forensic individual goes on to say,

> "Your Honour what I have tried to do was to determine the physical evidence of the holes in the clothes and I tested it on a sandbag for example, it gave me the best result. I was successful to prove that the hole must have been a close-range shot".

Later the expert expands on his experimental technique still further, and the method in which he recorded his results in a scientific manner.

> "Each and every time you shoot a test and it doesn't work and then to try and record it all doesn't make sense if it doesn't work. I recorded what I saw and I made the reports and I made the notes".

Page 198 of the Kriel inquest.

We have further revelation from this so-called expert on page 199.

> "I wanted to shoot a close range shot on the right background and in the right way without tearing the hole as it is torn where you see it there".

And the expert goes on to say just how important the background was by saying at line 28 on page 199 as follows:

> "I started realising with my tests that what I have behind the cloth has a big influence on what happens to the cloth".

In answer to the questions posed by the presiding magistrate the following is of great enlightenment.

> "And if you take the firm part of the pig's stomach and you shoot through that did you find similar evidence?
>
> No the close range shots blew out, it made large holes".

And further the Court says the following:

> "In other words only the sandbag gave you the same effect as your evidence of the close-range shot?
>
> That is correct".

Now let me try and explain to you what was happening here. The expert on the other side clearly understood and knew that the background in which you performed your experiments had to be exactly that as was the case when Kriel was shot. You had to deal with skin, with unresisting, yielding material such as skin. He realised that you could get different results on the clothing depending on what background you had. And so he altered the parameters of the experiment in such a way that he could obtain the result that he wanted and in so doing refute my evidence, which is in fact quite the opposite, he didn't refute it, he proved, instead of firing ten shots or 20 shots as I had done, he fired 200 shots and proved exactly what I had found.

This evidence, if one can call it that, was given before one of the forensic science doyens. It was given in front of a magistrate, and nowhere in the subsequent judgment or in the subsequent questioning is a single question raised about this nonsense.

I would like to make the following comments about this and to say what I see the experimental as it was for this expert.

1. Keep only those results which agree with your pre-conceptions.
2. Alter the parameters until the desired result is obtained.
3. Start off with the desired result in mind and don't stop until its obtained by whatever method. Use a pea-shooter if the gun won't do it for you.

Nowhere is this excruciating unscientific approach commented on by the Bench, and this sort of experimental design would get a standard 6 pupil failed for total lack of comprehension. Why did the assessor not comment on these experiments? Why did he allow this charade to continue without adverse comment?

That the distance was of considerable relevance was clear, otherwise neither I nor the State would have expended so much energy on the issue. It's quite clear that the Court and the police expert had a problem with this hole in Kriel's clothing.

The Court itself became involved in this, and clearly after I had challenged the Police expert on the nature of his tests and the lack of any controlled evidence, the Assessor and the Court clearly didn't understand what was meant by control. Because the last question asked to me by the Court in this was quite illuminating. This question was,

> "Did you have a control for the shots that you fired through the clothing?"

Now once you have set up the identical conditions, that itself is the controlled experiment and clearly this magistrate didn't understand that. And it's difficult to convey to this hearing the smug satisfaction with which that final question was put to me by the Court. It was as though the Court had caught me in a fatal flaw in my own experiment design, and yet all it had done was to underscore the total scientific illiteracy of the man asking the question.

It's interesting now to read the judgment in that case, where the Court, presumably with the concurrence of the Assessor makes the following finding on page 10, line 12.

> "The entrance wound in the clothes shows irregular size".

With the greatest of respect that was not what the argument was about. The Magistrate's very question to the expert showed that he understood what the question was about earlier, and yet he makes this finding subsequently in the judgment when nothing can be done to alter it, when nothing can be done to change the misconceptions for posterity which he created by this.

This should be compared with the passage supra in line 28, line 30 where I say it's very difficult to argue with this kind of finding, plucked out of the air and supported by no evidence. The Police had a problem, namely with a contact shot, no tests that they produced could support their position, and in order to sustain their version they had to falsify the experimental design and this was done without a murmur from the assessor and indeed with the active connivance of the Bench. When the Magistrate pulled the legal rabbit of the particular nonsense about the torn edges of the wound out of the hat, there was nothing that anybody could do about it.

It just shows what anybody who opposed the State were up against in those dark days.

And one is reminded of that hard-pressed advocate of Louis XVI who commented wryly when he came to court to seek judges, and he said **"I found only prosecutors."**

There were many other problems with the marks on Ashley Kriel's body. The angle of the burn was incompatible with the angle of the pattern on the skin. The size of the mark should have been smaller than were measured. There were many. They were none of them commented on. And there was bland evidence put before the Court in order to exonerate the Police position.

We must remember that the weapon used in this killing was at the very lowest end of power of firearms. It was a calibre .22 automatic pistol. And we must consider this piece of evidence when we examine the next case where the goalposts were subtly changed and moved in favour of the State, again without any comment, adverse, from the State experts who were sitting in these hearings.

In particular it was important that in the Kriel case a burn mark had been produced on the skin of Ashley Kriel with a weapon that had been discharged through two layers of clothing and this produced no adverse comment from anybody, any of the medical experts in this particular inquest.

Before leaving the Kriel inquest I want to just mention that the post mortem refers to "circumferential abrasions involving both wrists of the deceased". And there was little doubt that these were produced by the handcuffs and furthermore it was very unlikely, in my view, that the marks were produced after Ashley Kriel had been shot through the heart.

And so the position that we had was, that, and it should have been explored, as to how a man with handcuffs on both wrists could have put up such a ferocious fight and why in the fight the officer of the Police didn't throw away the firearm that he had firmly clutched in his hand to allow him to participate in the attempts to subdue Kriel more effectively. I don't know. Like the many people who slipped on soap, fell out of Police windows, all the other explanations, we are never going to know for sure.

Lastly, we should see the harsh censure of the presiding officers in cases such as these being reserved for anybody who attempted to oppose the State juggernaut. One should see the remarks made by the same presiding officer about the collusion between the Police to produce their sanitised sworn affidavits, line 28 in the judgment makes it quite clear that the Police have sat down to prepare the affidavits in this matter which were word-for-word copies of each other, and the best that the Court could do in that matter was to launch an earnest appeal for this never to happen again. And that slap on the wrist must

have really hurt the Police. All of this without murmur from the professionals involved in the State side of the case.

Let me turn now to another event which this Commission has already heard evidence about. It was an event known as the Guguletu 7 shootings where 7 young men were shot at the Crossroads near Guguletu.

Briefly, the case arose as a result of certain counter-insurgency actions allegedly performed by the Police at the Crossroads in Guguletu. The alleged results, if we are to go by the Police report, is that a sharp action was enjoined in which 7 alleged terrorists were killed. Unfortunately Tony Weaver, from the Cape Times, did his own investigation and reported a somewhat different story which did the Police no credit. His story was of the police executing, out of hand, alleged terrorists.

By the time that I entered the matter an informal inquest had already been completed and the findings of this informal inquest, before the same magistrate to whom I referred earlier, were exculpatory of the Police. The State then launched a prosecution of Tony Weaver for publishing these vicious and untrue reports.

I was involved, with others, in the Weaver defence, and after a consideration of the Police statements, which were again of the sanitised version, it became quite clear that the analysis of the ballistic evidence on the bodies could not support the Police version. Suffice it to say that in the Weaver trial the State called no experts whatsoever and Weaver was acquitted. And the nett result of this was the ordering, by the Attorney General, of a second inquest, this time a formal inquest.

It will be tedious to cover in detail the whole of the forensic evidence, and so I shall concentrate on two of the deceased and show how the Court dealt with this particular piece of evidence.

The first individual I shall refer to by the death register number of 700/86 was allegedly shot by the Police

at a distance of approximately six to seven metres. That can be seen from the transcript of the Weaver trial on page 154. The Court heard evidence that a four centimetre irregular bullet entrance wound was found on the right side of the head and a felt wad, I repeat that, a felt wad was recovered from the brain tissue. A second wound of four centimetres diameter was noted at the angle of the jaw.

I would like to hand up to the Commission photographs of the individual concerned and I would

like to discuss it briefly. And before continuing with this evidence, if I may, with your permission, I would like to say a little bit about shotgun ballistics.

When a shotgun is discharged the variable number of lead pellets are blown out of the muzzle of the gun and together with these pellets a wad is blown out at the same time. The wad in the cartridge keeps the pellets separate from the shot and allows for more efficient operation of the cartridge. As the pellets exit from the muzzle of the weapon so they start to spread and that spread can be used to give an indication of the distance between the shooter and the target at the time of discharge. The wad is ballisticly very inefficient and doesn't travel very far and loses energy very, very rapidly after it leaves the muzzle of the gun.

Now that's important because when you find a wad in the tissues, embedded in the brain, what that means is that it suggests that the shot is fired from close range. When there's a lack of spread of the pellets from the same firearm it supports that contention that the shot is fired from close range, and above all if you look at the head of that deceased you will see that the jaw is virtually blown apart. That supports a close range shot and the discoloration of the tissues supports a close range shot. All of this tends to indicate that this individual shot at close range by two shots from a shotgun.

Let us examine how the expert for the State deals with this piece of evidence. Again an eminent member of the forensic profession in this town. Firstly, he fails to discuss the wound number one, the jagged wound in the man's head and it is clear from the evidence that the police shot the man with the shotgun. And in the evidence at the Weaver trial the Police make it quite clear that they fired the shots with the shotgun. The only other policemen who could have fired a shot, which would have hit this man in the way that we see, was unable to explain the nature of the wound because he was armed with an R1 rifle and none of the wounds on this individual, in the face area, indicate that they were with an R1 rifle.

In the original affidavits before the first informal inquest the Police statements are strongly supportive of the position that the deceased was shot by a shotgun. And now in the second inquest we have the State trying to discredit the evidence, which the family led, by trying to prove otherwise, despite the evidence.

The State expert goes on to justify his views and to justify the nonsensical report of the State pathologist which was inaccurate and sloppy to the point of ridicule, by saying,

> "I see a round wound at the bottom there which is very suggestive of an entrance wound, caused perhaps by a bullet. And then the rest of the splintering of the face, of the jaw, may have been due to secondary missile fragments".

With respect one needs a great deal more than the "eye of faith" to see what this expert was describing. I don't know whether this was ignorance, stupidity or dishonesty, and the State are stretching and were stretching at the time to fit in the evidence with what they wanted, and simply ignored any other evidence.

It's also very interesting that if these individuals of these so-called State experts really did believe the things that they were saying, it's most illuminating that none of them came forward at the Weaver trial to say these things.

The reason for them ignoring the first wound in this particular individual is very, very clear. They wanted to avoid the inescapable conclusion that the shotgun was used at close range in contrast to the police evidence given at the first inquest and the Weaver trial. And it was an example again, in my view, of the State experts attempting to bail out the Police when they were in trouble.

All of this was conducted with no comments from the Bench or Assessor about the pathetic nature of the post mortem reports and about the attempts made to confabulate the evidence that we have before us.

Let us now look at deceased number 702. He was a man that allegedly had been killed in the midst of this sharp action, where there were people running all over the place and shots were being fired. It was a mini war.

The pathologist who described the post mortem described it as follows:

> "A two centimetre glancing bullet entry wound was found at the back of the left buttock. The track of this wound could be followed just under the skin to an exit wound seven centimetres above and medial, i.e. to the inside, of the one in the buttock, and an elongated burn mark was found along the back extending from this wound in an upwards direction".

Why is that burn mark so important? A firearm produces a burn mark on the skin when it is fired at very close range. It is not the sort of thing that you find in a sharp action where people are running around and shots are being fired. You don't snuggle up to your opponent in order to fire the shot which

would have had to produce that result, particularly if your opponent is shooting back at you.

At the Weaver trial my evidence was quite clear, namely, that this was a close range, probably contact shot, from an R1 rifle which had produced the burn mark and the two wounds in the buttock and I differed only from the State pathologist in my view of which was the entrance wound. My views were based on sound forensic evidence to be found in any forensic textbook.

The mark was described as a burn in the original report, it looked like a burn, and I hand in a photograph of that particular shot. You will see it is photograph no.13. And the mark looked exactly like the burn from a flash protector and the bullet traversing the skin would not produce such a mark but would produce a linear abrasion which was quite easily distinguishable from the mark that you have before you.

The Assessor in this hearing, the second inquest, then chipped in to the inquest and suggested that as one bent over the hollow of the back would disappear. Now the hollow of the back is very important because a bullet, which is what the State was suggesting, they were suggesting that a bullet had followed the contours of the back in order to produce the mark on the deceased. But in fact if one understands that, the back is hollow and a bullet would not follow those contours, whereas a smoke burn would.

But not only that the Assessor then jumped into the fray to try and rescue the situation by saying that if the man had bent over it would have produced a flattening of that hollow and so the bullet could have done that. But it is such a nonsensical proposition. It has no merit other than to rescue the Police from an untenable situation that was developing.

Let me turn now to the way in which the State expert handled the evidence. The State expert in fact agreed with my findings and the other family experts that the entrance wound was the upper of the two wounds. He did that initially. But he goes on to say, and I quote from the record exactly:

> "That is not my final opinion...."

said this expert,

> "...I said it is possible to explain the appearance of this wound as having been caused by a very near firearm injury with smoke and explosive gases burning the skin. That was our position. But...."

says the expert,

> "... one must consider the other possibility of a friction or brush burn from a high velocity

> bullet even at a greater distance and not necessarily a near wound, and this cannot be excluded".

The expert goes on to say that that longitudinal wound had the appearance of a "peri-mortal parchment-like, dried-out wound", and that is why he believed that it was indeed a bullet traversing the skin.

I want to show the Commission a photograph of what a peri-mortal bullet wound of the skin, skimming over the surface of the skin, looks like. If one looks at the photographs that I give there those photographs of a deceased who was shot by the Police when they again went to arrest him. There are a lot of bullet holes in him. But one of the bullet holes you will see extending across his right thigh, and an enlargement of that bullet mark along the skin is seen on the bottom of the page. With respect, learned Commissioners, you don't have to be an expert to see that there is no similarity whatsoever between the mark produced by that bullet over the skin and the mark on the back of the deceased in the Guguletu shooting.

The expert in this particular case goes on to say, and here I refer to the goal post shift that I referred to before, and his answer to the following question which was put to him. The question is:

> "In order to sustain burns as suggested by Dr Klatzow the deceased would have had to remove his clothes".

And the expert answers,

> "Well, first of all the area in which the parallel lines are drawn in this photograph is the best example, to me, of what I talk about when I say that I see a parchment-like dried out abrasion. I certainly do not see the two clear parallel lines. And that portion of the upper portion of the wound looks to me typically like a peri-mortal abrasion which is dried out and parchment-like. Obviously if we talk about flash burns I would agree that if there was a flash burn or a burn from a close wound and the person was clothed I cannot see how we could get that burn through the clothing unless of course it was totally contact wound so that the flame could get underneath the clothing".

Well of course that's exactly what I was saying.

But the point that I wish to make is that this expert had been present at a previous trial where he

saw no problem with a very much weaker weapon producing a similar effect. So the goal posts were shifted and it became very difficult because those goal post shifts were always done with the weight of the authority of that particular expert behind them.

It's quite clear that this State pathologist had trimmed his evidence to favour the State line and in so doing had had to virtually abandon his previous views. And he even went so far as to say that he had never seen a burn like that and yet he offered up, without any experimental evidence, all sorts of explanations.

And again I say we have a senior State pathologist lending his stamp of authority to shore up this disgraceful performance that was masquerading as an impartial inquest.

Now what is the relevance of all of this? The relevance is that Tony Weaver described, and was prosecuted for describing the Police shooting unresisting men. And what this evidence would have shown, had it been accepted, was that the Police had walked up to an individual lying on the ground, put the muzzle of a high-powered rifle onto the man's body and pulled the trigger.

I just for completeness want to say this, and I want to read to you what the Magistrate says in his findings, and I will read in the vernacular.

> "This last-mentioned wound in the buttock is, however, not fatal and the Court, including the learned Assessor, had before argument, when there was written argument by the legal representatives, requested that they indicate whether it was clear to them why, in the Weaver case, so much attention could have been given to this long black mark which has very little to do with the deceased's death, and whether this Court should, in any way, give any attention to that issue in the light of the fact that there was no eye witness or expert who can throw any light on that".

I can only say this, the Magistrate did not pay attention to the evidence or we have an inference that the Magistrate was determined, together with the Assessor, to keep out any evidence which would have shown the Police in a poor light and which may have supported the family version.

The fact that the wound did not kill the deceased was irrelevant. It went to the heart of credibility as to how the Police had gone about this particular interaction.

These are by no means the only cases which I could use to illustrate the extraordinary failure of the

men and women in the employ of the State to give impartial and honest evidence under oath. They may have acted stupidly, or ignorantly, or dishonestly, I don't know, but underlying all the failings there was a dark, evil and malignant thread which ran through all the evidence. The State line was always favoured and punted to the derision and exclusion of all else.

I am aware that a head of the Forensic Science Laboratory in those dark days had issued an order that his staff were forbidden to assist me, to talk to me, to have any dealings whatsoever with me. That information was relayed to me by several of his staff.

During the case known as the Mandrax Factory case in Johannesburg I arrived home one evening to find the inspectors of the Medical Control Council from their head office in Pretoria who arrived on my doorstep and accused me of every contravention in the book relating to my licence to have Schedule 7 drugs in the course of my work. Those charges were dropped by the Attorney General.

But it was no coincidence that a member of the Forensic Laboratory had spent time the previous week closely closeted with that head of the Medicine Control Council in Pretoria. And one can only but see that that was an attempt to intimidate people who were in any way prepared to act against the State.

It was also no coincidence that the Police were sent by the head of that infamous laboratory, as it was then in Pretoria, to harass me in terms of the Firearms act. Those charges were swiftly dropped by the Attorney General with much anger expressed by the Attorney General incidentally. I am pleased to say this, that in the road to recovery in South Africa that laboratory, since the departure of that odious individual, that laboratory has moved a long way on the road to self-healing and it provides a better service now than it ever did in the past.

There was, learned Commissioners, in my view, a conspiracy which was to be found in all the organs of State which acted in a concerted way to disable and discourage any attempts to investigate it in an impartial way, and to discredit those who failed to be discouraged. This conspiracy was found in all walks of the Civil Service and could never have happened without the passive or active cooperation of the Bench, together with other branches of the Judicial Service. This was most apparent in the Magistrates' Courts although there were instances in our Superior Courts which did not escape the apartheid ethos.
It was alleged for many years, and this Commission has heard untold evidence that torture was the standard method of police investigation. It was never commented on by the forensic practitioners in this

country. And when your Commissioner Wendy Orr raised her lone voice the chorus of support which she got from her colleagues was deafening in its non-existence.

When John Gluckman said the same thing later in the decade he was vilified. He was insulted. Not a word was raised by his colleagues who, incidentally, had sworn the same oath of fealty to their patients.

The Courts could have stopped all of this torture in its tracks if they had been a little more willing to cast the sceptical eye over the large numbers of confessions in serious cases, together with the constantly recurring theme of confession by torture. I am shamed to tell you today it has not stopped, it still goes on. Peter Jordie has uncovered evidence today, in the New South Africa, of torture by electric shock, the method which I refer to as the Eskom method. You can get a confession out of anybody as long as you just connect them up to Eskom you will get a confession, I will get a confession out of you if I were to do that. It's still going on.

The professionals in this country owe the people of this country and owe the people of this country a duty of care and they failed singly to discharge this duty. They shored up and gave succour to a system as monstrous as any in the dark annals of human crime.

Every time they failed to censure the excesses of the Police; every time they failed to see the growing evidence for torture; every time they allowed bland exculpatory decisions from the Bench to go un-commented on and uncensored they added another clause of tacit approval to the bullies charter which enabled the Police in this country to make that cap badge into the mark of Cain, into a badge of shame.

We have, in the New South Africa, to guard against this ever happening again. The allocation of power must be measured and carefully checked with the necessary counter-balances. The Police, the Bench, together with all organs of State should be subjected to the minutest scrutiny. And the freedom of speech, which is enshrined in our Constitution should be used to the fullest effect to prevent a repetition of our shameful past.

We must never again allow the powers that be to bring about the conditions in which the State organs could, with impunity, commit that vast squalid catalogue of crimes that came to characterise the apartheid regime.

During that time I many times wanted to go to the Press with issues which troubled me, and every

time I was persuaded to work through the courts. I am saddened to say that this was a mistake. Because my experience of the courts, particularly in courts involving political crimes, was this, that they were not courts of justice, they were courts of law, National Party Law.

Thank you for having listened to me.

ADV POTGIETER: Thank you Dr Klatzow. Thank you for bringing a forensic perspective on some of the matters that this Commission is seized with. And bringing into contention the situation about the administration of justice which is another issue that will receive attention from the Commission. Once again, thank you very much.

CHAIRPERSON: Thank you Denzil. Any questions? Thank you very much Dr Klatzow. We have to be even-handed and we have found in the submissions that have come before us and the testimonies of different people that there has been a pattern such as the one that you are describing, and all we can hope for is that those who make the laws in this New South Africa will take very seriously into account what did happen when considerable power was vested in a few hands, where a concentration of power led to its abuse. Thank you.

We should have broken at one o'clock. It's just past quarter past one and so I think we should maybe - quarter past - let us try - she has to be obeyed says two o'clock. We will try and be back at two. Those with blue and yellow stickers, unfortunately budgetary constraints make it impossible for us to have an African feast and so we have to engage in the invidious thing of inviting only a few people, those with blue and yellow stickers please the seventh floor and we will resume here at two o'clock. Thank you very much

HEARING ADJOURNS

EXPERIENCE OF A TOWNSHIP DOCTOR

ON RESUMPTION

MS MKHIZE: Dr Bletcher I would like to welcome you. Before you give your submission would you take the oath.

MARK BLETCHER: (sworn states)

MS MKHIZE: Your submission takes us back to peoples' experiences before people were detained, work which was done in the townships. Would you start.

DR BLETCHER: Thank you very much Hlengiwe. Good morning members of the Commission and thank you for allowing us this opportunity to give evidence.

I'd like to begin by paying a tribute to those health workers who were there when times were bad; the times when people were shot in the townships and it was almost impossible to get a health worker to give care; the times when detainees had come out of prison or out of police stations had been tortured and it was very difficult to find a health worker to be there; at the times when hospitals were segregated on racial grounds and it was very difficult to find health workers who would stand up and say what was right.

And I would like to just give some examples of some health workers in this category, although it's obviously impossible to name many. But people like for example like Dr Di Hewitson, who I worked with at the SACLA Clinic in Crossroads, who in her own quiet and humble way, through the most difficult times, entered into the townships and gave of caring and healing to people.

To Dr John Frankish, currently director of the Cape Metropole Region, who after a whole day of treating people in the day hospital in Guguletu where he worked, would come and help us in the clinic in Crossroads when we were treating injured people at night.

People like Mr Ken Ngcu(?), a driver of St John's Ambulance, who through the most difficult and dangerous periods drove right across the townships selflessly giving of everything to help the needy at that time.

People like Dr Lesley London who, ever since I've known him over the last 10 years, will phone every three weeks to say, "can you please come and attend at this funeral or this meeting or whatever because something has to be done".

People like Dr Fazel Randera, who from the National level, in those most difficult times supported us in setting up a detainee services and services like that in some of the most difficult settings.

And people like Professor Trevor Jenkins, and Professor Frances Ames, who for those of us who worked in the most difficult ethical situations, provided some kind of ethical framework or parameters by which we could judge what was correct to do.

I want to give some evidence about my experiences in Crossroads and Duncan Village between the years of 1985 and 1987, and I will start off in Crossroads Clinic. Now the story of Crossroads is fairly well-known but I mean the failure of the State started off as a primary failure to actually even recognise the existence of that whole area as an area which had a right to exist. So that up to 100,000 people were living there and the State had failed to provide even the most basic of health services. They hadn't put a day hospital there, the most basic environmental services were lacking, like water.

It was in that background that the SACLA Clinic was put into place by a group of committed people. The State persisted in hardly recognising the Clinic in its support, to the extent that shortly before the Crossroads massacres broke down in 1985 we had received funding from the State for about two health worker's salaries, and we had to use those funds to basically pay about five health workers out of those funds.

In the Crossroads Clinic I think that we had an atmosphere of care and healing which was something which was very meaningful to me. I think we had a lot of dedicated health workers. And when the township went through some of its most difficult times I think we were a place of refuge. We had close relationships with the community and had a Clinic Committee and delivered a fairly comprehensive primary health care service to the Crossroads community.

In February 1985 the, what is now known as the Crossroads Massacre, occurred, and I would like to briefly explain just some of our experiences in that as a health worker.

On the first day, February 18 1985, we came to a police roadblock in Crossroads and the police said that we couldn't go into the township because stones were being thrown and so on, and health workers gathered some one or two kilometres further down the highway. And I remember feeling as a health worker at the time, that was the first time - I had never before been into a dangerous situation in a township, and I remember at the time feeling incredibly torn as to what I should do, and what was the correct thing to do and what was right for me and what was the correct thing to do for my patients.

And I remember at that time people said to me right, some people have to go - what should we do,

and a number of health workers immediately, and it was really a tribute to them, immediately said we feel our responsibility is with our patients and they went through, they walked through the bush along the roads with roadblocks and burning barricades and so on and they walked into the Clinic and gave care.

Some of us they said we need to get some supplies like resuscitation equipment and things like that for the many patients who are going to be injured, and I was one of those who was asked to go to get the supplies and at that time I felt very grateful because I hadn't made up my mind what the correct thing was to do.

So the first thing I did then was to go back to the teaching hospital where I had shortly before then been an intern, a houseman, because I had qualified fairly recently before then, and I went to the superintendent, and said to the superintendent, there are going to be a lot of people dying and being shot in Crossroads today and we desperately need equipment and the Superintendent of the hospital said no it's got nothing to do with us you must get the equipment, it's not our problem. Anyway we managed to get some supplies, essential supplies from Red Cross.

And I remember several times later on in that day phoning through to the Clinic and hearing the most terrible stories. Health workers would say that there are a lot of people being shot and so on. I remember one particular phone call where I spoke to a lady whose name was Nomazizi, and she said to me, "Mark it's terrible here. Injured people are being carried in all the time, people are bleeding, people are dying", and then she said "my baby, my baby, the teargas, my baby", and it was at that point that I just felt that I had to go into the township.

So I phoned and said okay I'm coming into the township, and they said no well don't come in right now come tomorrow morning because we are going to be very tired after not sleeping through the night.

And the next morning we came into the - we parked again at the side of the highway, the N2, which is opposite Crossroads and we walked through the bush and coming to the Clinic we walked across Klipfontein Road, but the road was blocked with tree trunks and boulders and stones, and we embraced the health workers who had been through the night. They had been through a very difficult experience. There were smouldering remnants of barricades around in the road.

In the Clinic many of the examination couches had been converted to beds and on them the injured lay covered with bloody bandages. We did a ward round and decided who could be discharged and who

would need referral to major hospital for admission and specialist treatment.

Not long after that firing started up and soon mini-buses and cars arrived screeching to a stop and unloading their injured. Somebody would help with stretchers to bring injured persons in. Some of the injured people hopped in supported by one or two friends, coming in from between the shacks. We would rapidly check their state of consciousness, their breathing and their airway and then remove their clothes to see their injury. We knew the most common cause of death would be blood loss and resulting shock, so our number one priority was to stop bleeding. Most of the injured had been shot with shotguns and the severely injured patients usually needed urgent fluid replacement and rapid transfer to hospital. Throughout the day the injured poured in. Often they would describe how they were shot, almost invariably by Police. Many were young, the majority between 15 and 25 years of age. People moaned with pain and parents and relatives sobbed.

The injured, as we saw them, did not appear to have had weapons to speak of. Most of them appeared to have fought with sticks or stones. Many women brought in their babies who had been in teargas and we also had to treat asthmatics and people with chronic chest diseases who had been made worse by the teargas. When a body already dead was brought in we would certify the person as dead and then usually the nursing staff would clean the body and wrap it in a particular way.

By the end of the first two days we had treated around 200 people who had been shot. Just for an example I would just like to show members of the Commission, this is just like a list of pages, each of them of just a person shot, each page is about 30 lines, and it just goes on for pages and pages and pages of people who were shot and that's just during the two days of February.

I would briefly like to describe some of the injuries that we treated. This type of shooting, particularly by Police continued right through 1985 and by November we had treated over 500 people that alleged, and according to their injuries, appeared to have been shot by Police. And of those 500 people who had been shot, 464 of them had been shot by shotguns and 31 by rubber bullets, and 5 by high velocity bullets.

13 of the patients we saw died and 65 of them had serious injuries which needed referral. The kinds of serious injuries we saw due to shotguns were penetrating eye injuries with blindness, 12 people; penetrating chest injuries, seven people; penetrating abdominal injuries, seven people, and head injuries

with neurological loss, six people; and severe soft tissue injuries, 14 people; and fractures or joint involvement, 15 people.

It was quite difficult to follow up the patients but we treated many patients with permanent disabilities, including blindness and hemiplegia, nerve palsies and contractures and so on. People with injuries from rubber bullets included things like fractures, including a fractured skull, fractured mandible, acute abdomen with a partial hepatectomy and so on. We also treated a large number of people that had been beaten, many with batons and quirts and they had sub-junctival haematomas which is bleeding in the eye, ruptured ear drums, scalp lacerations, cut lips and so on.

Teargas was used very frequently and disrupted the work in the Clinic on a number of occasions. Severe problems were usually seen particularly when it was shot in a confined space, like we saw a patient who was brought in unconscious after being teargassed in the back of a police van.

The patients we treated were usually young, in fact 43% of patients were less than the age of 20 years, and we saw five children less than 10 years of age who were shot, and 36 children who were shot who were less than 15 years old, well between the age of 10 and 15 years old, 36 children who were shot.

Now I'd like to describe some of the difficulties in referring patients to hospital. Now initially we had difficulty referring patients to hospital because ambulances wouldn't enter into the area. Subsequently we then had to refer patients to hospital with vans and other kinds of vehicles which would take the person outside the township to hospital, and then we found out that a lot of our patients were being arrested. In one particular hospital a whole ward of patients was held under police guard. In another hospital which we visited all the patients that we referred who had been shot, their names were being underlined in red in the admissions book. We spoke to some of the staff and they said no, well the police were being given these names. In another hospital most of our patients were not arrested but we had one or two cases of patients who we referred through and they were arrested.

That led to fairly serious problems because later on in the year when we wanted to refer patients then who were shot later on, the patients would then refuse to go to hospital, often. We frequently had patients refusing to go to hospital even though in some cases by that stage we - because in some of the hospitals conditions seem to have improved. For example I remember one patient who had a septic hand injury who we really thought needed to be admitted potentially for surgery or intravenous antibiotics but

refused to go to hospital because he feared he would be arrested.

We had difficulty in getting emergency equipment. I have given some examples of that. In some cases I remember some of our staff having to walk across the N2, across roads that were fairly dangerous at the time to get equipment which would not be delivered into the township even by members of the provincial staff.

The Clinic suffered several searches by security forces demanding records and information about patients who were injured. I remember one particularly vivid case where about, literally about 60 police and army people came to the Clinic and they wanted to know the identity of people who had been shot and they wanted to take records, and wanted to know who was the staff member who worked there and there because someone had told them about that person and so on. They tore down posters off the walls of the Clinic and so on, but I am proud to say that the Clinic resisted that type of intimidation.

There was also various harassment of health workers. One of our doctors, Dr Ivan Thoms was detained during that period. Dr Bressick was arrested in one of the areas just adjacent to Crossroads and held. Dr Myburgh our dentist was charged for illegally entering a Black area without a permit. One of the other members of our staff, Mrs Peter, was held for many months before being released.

I'd briefly like to talk about the role of - well our interaction with lawyers around the period. We treated a lot of people who were injured during the period and we thought - we tried to make legal services available to them because we thought a lot of them would want to bring cases against those who had injured them. Perhaps I'd like to just show you one photo here if I may. This is a photo of a young boy of 14 who we treated at the Clinic. He was shot from the back at fairly close range with a shotgun. And why that young man was particularly, I remember him particularly well was because of all the 500 people we had seen who had been shot he was the only one which we ever ended up giving evidence in court around. And that evidence that we gave wasn't evidence of him laying a charge against those who had shot him, it was evidence kind of in support of him when the State charged him with public violence. So of 500 cases at least, of people who we had treated, we are aware of only about one or two people who ever brought a successful case against those who injured them.

The role of the Press was very important during that period, and that contrasts with my experience in some other environments. Because it was an NGO the Press, we had easy access to the Press and the

Press was very, very helpful in highlighting abuses during that period.

We submitted an article to the South African Medical Journal around that time of 500 people that we thought had been shot by Police and problems we were having with referral to hospitals and so on, the South African Medical Journal at the time refused to publish that article. We felt that they could at least have given some response to us which would have supported the difficulties that we were experiencing during health workers of that period.

We experienced several difficult ethical issues during the period as health workers. Some of the difficult ethical issues that we confronted were issues like one day we treated three women who had been beaten by a People's Court. They had received a 100 lashes each by a People's Court and the youth from this particular People's Court placed a lot of pressure on us as health workers not to complete assault forms and things like that. It was a difficult situation.

We were put into difficult ethical situations when we were confronted by vigilante groups who became known as Witdoeke. Sometimes they didn't want particular staff members to work in the Clinic, the didn't want us to treat particular patients and so on.

And I've mentioned some of the difficult ethical situations we faced with the Police.

We also treated, shortly before the burning of the camps close to Crossroads, about 15 people who were tortured, many of them quite severely. I will just read you a very brief extract from just one of them. This young man was arrested from his home, taken to a local police station in Cape Town. He says,

> "I was given electric shocks. My whole body was affected. They took the cap off my head and asked more questions. They then put the cap back over my head and held it tightly around my neck. I could not breathe. This continued with the shocks. One policeman put my head between his thighs while the other hit me with a cane and others kicked me. I could not tell how long this continued. I was hurting and suffocating".

Torture was not uncommon during that period and we saw a lot more of it in the Eastern Cape, which I will come to shortly.

One of the people we saw tortured, I can perhaps show this picture as well to members of the Commission, was a community leader in the Crossroads area. This particular gentleman had - a very dignified and respectful man, and he had had electric shocks. The picture I am passing around we thought

at the time that that showed fairly clear evidence of - he had a small ulcer with little abrasions around it where the electrodes had been applied. He was actually beaten and tortured on more than one occasion.

I remember one particular experience with that gentleman, who was quite a prominent community leader at the time, where he was then arrested and sent to Valkenberg Hospital, which for those of you who don't know Cape Town, that's a hospital for mental illness. And I remember visiting him in the very high security unit of Valkenberg Hospital where it's kind of very - it's almost like a fortress-type arrangement, and it was the most strangest situation, that the person who let me into this ward was a young woman, barefoot, and here he was - I met this particular man and we spoke to him and he told me some of the things that had been happening to him. Here he was being held in a high security mental hospital shortly after we had seen him being tortured and it wasn't more than a month or two after that where his whole area was in fact burnt out in the Crossroads strife around that time.

For pressure of time I think I must proceed fairly quickly. In 1986 I then went to the Eastern Cape and went to work in Duncan Village Day Hospital in the township of Duncan Village in East London. Now in Duncan Village the whole day hospital had been closed. Their response to the injuries and what was happening in the township was to to just close the hospital. Now it's quite a big township Duncan Village, but it was just completely closed, so there were no health services then available to people. And then after several months of the township being completely closed the nurses went back, but the doctors didn't go back, so there were no doctors in the hospital at all.

They had the strangest system of operating. The nurses had to see the patients and fill in the records and say what medicines they thought the patient should have, then they had to send the folder up to the nearby hospital and the doctor had to sign it. It was a very strange system, and it then had to come back to the day hospital before the patient could go home. So the patients waited for hours and hours and that went on for many, many months.

So I went to work at this hospital and the situation in the Eastern Cape was very difficult. Frere Hospital, which was the local hospital in East London was completely divided on racial basis, hospital apartheid was very strong during that period. I remember often working in casualty, there was of course a White side to casualty and a non-White side to casualty and the non-White side of course there were always lots of patients, and the White side there was always just one or two patients, but there was

continual pressure why were we not at the White side? Why were the people at the White side waiting and so on.

I was hauled over the coals at one point by the Superintendent because I had attempted to eat in the dining room with the non-White nurses because the dining facilities of course were all segregated during this time.

To enter the township obviously before commencing work there with the help of people like Dr Trudy Thomas, who is currently the MEC of Health in that Province, we had to enter into negotiations with township community groups, but we were actually prohibited by medical authorities in the area from working in the community at all. They said go into the day hospital, do your work, and don't go into the community at all.

Now during that period in the Eastern Cape we saw a lot of very severe injuries, there was a lot of severe assault by Police, a lot of torture going on from police stations in the vicinity and we saw a lot of people with very severe injuries.

One of the particular problems which maybe needs to think through in terms of the future is being a State institution it was almost impossible to get access to the Press. If you wanted to get anything out in the Press we had to go through official channels, of course you know there was virtually no chance of it coming out.

I requested permission to do a thesis, a master's thesis on people that we were treating who were injured, because there were so many of them that we wanted to document what was happening, and after preparing like a 50 page protocol and so on, we got a one line response back from the Provincial Health Department, definitely not! No, nothing on this.

I must say that during that period we experienced really gross human rights violations and as health workers, the few health workers who were there who were progressive, I mean there was really absolutely no support. There was a complete failure of the profession to speak out on what was happening, really on any accounts. We were very isolated, except for the support of people like Dr Randera who were supporting from Joburg and so on.

We started a detainee service for released detainees in the East London area and many thousands of people had been detained without trial and that was the most astonishing and horrible period. Anybody

could be detained for anything, for any length of period basically.

One particularly strange episode happened in church, in the church in East London known as Roma, which I presume is the Roman Catholic Church, and the entire church was arrested. The police were under the impression that something was happening in the church and they arrested the entire congregation, and that entire congregation spent about six months in detention in the Eastern Cape. We first saw the detainees coming out of that episode after about six months they had been in detention. It was incredible. About 300 people were just detained in that episode.

We established this detainee service and many other organisations like the Descoms and the Black Sash and others, and Union organisations which still were able to function in the very harsh conditions of the Eastern Cape, gave a lot of support during that period. We tried to offer fairly simple medical services, screening, we managed to get a psychologist to help and try and do some kind of basic counselling. The conditions were very difficult. There were very few health workers' resources. We treated over a couple of months about 300 released detainees.

The first group to come out after about six months in detention contained a lot of the younger detainees, the 13 year-olds, the 14 year-olds, the 15 year-olds, the 16 year-olds, they came out after about the first six months of detention. In the next batch we treated a lot of the old men. We must have seen about 10 or 15 people over 75 years-old, about 5 over 80, and some of them were completely out of their mind. They were just - they had been in detention for so long they were completely disorientated.

The torture that we came across was fairly extensive. It occurred especially in the police stations rather than in the prisons and included things like what's known as "Boeing", where a person is tied, say by handcuffs, over a pole and kept there for say two days or something like that. People having rubber tubes put over their heads, electric shocks, severe beatings, explosions, a whole range of things.

We saw a lot of people who were in solitary confinement. If I remember the emergency regulations correctly people could be kept in solitary confinement for up to 14 days. We saw people who were in solitary confinement for up to a year alone, and we saw a lot of people with quite severe emotional effects from being in solitary confinement.

The kind of response we got from the medical profession in the area was fairly typical. I would just like to read something from a newspaper article of the period. This is from the Daily Despatch in East

London. The heading to this newspaper article.

> "Prisoners in solitary confinement get better health care the Court told".

The senior district surgeon of East London, I won't mention his name here because his name is in the article, he was testifying in the trial of two people who were charged and the magistrate Mr Dapula asked him the question, he said,

> "Is solitary confinement an inhumane way of keeping humans?"

and this is the response of the senior district surgeon from East London. He says,

> "From my own experience solitary confinement is not the image conjured up in books and various political propaganda pamphlets".

the doctor said. He said,

> "Those in solitary confinement were in constant communication with prison guards. Every complaint in the Border area was investigated".

He says,

> "Only one or two people in the Border area had been sent away for psychiatric help after solitary confinement...."

but agreed that there was always the danger that a person could have an abnormal reaction.

That was the kind of response that we had from the kind-of official establishment during the time. We wrote back to this particular district surgeon and said we had actually seen about 300 released detainees and a lot of them had been in solitary confinement and we were seeing fairly severe effects on them. We took the liberty of sending him a list of about eight references on care of people in detention and so on.

We also made submissions to various people on conditions in Fort Glamorgan which was one of the prisons in the East London area.

Now as health workers we also suffered some harassment because of our involvement. The Security Branch kept quite a close presence around our detainee services clinic. I was questioned on one occasion when they came to ask me what the hell we were doing here, what we were doing.

Then a short time after that all the tyres of my car were slashed outside the hospital where I was working in the Eastern Cape. I got my car fixed up again and about three nights later in my home in East London the same thing happened. All my tyres were slashed. And then a few weeks after that we were

taking detainees home to Ndantsane township just outside East London, and one of my tyres burst and we went off the road and I nearly had an accident. Well that happened twice.

Just in summary, because I'd like to end now, I mean there is no question that in the townships in the mid-eighties, which is the period I was there, that there was gross abuse of human rights. There were a lot of people who were shot, killed, tortured, and my own experience was that our profession, which is the profession which we would like to be proud of, was incredibly silent about what was happening. And that the profession consistently refused to get involved in issues which they said were political. I think, certainly in my mind, there is no question that the profession has consistently, over many, many years, refused to take a stand on social issues. That is something that we have to address. Thank you.

MS MKHIZE: Maybe just one question to ask you to complete a picture. You have, I should think, fairly described to us the experiences of concerned doctors or committed doctors who were coming from outside to the townships, but there were also, I suppose, other health workers who were working and living in the townships. From some of our hearings we have heard about doctors like Dr Asfad(?), Dr Luthuli in KwaZulu Natal, have you got a comment as to how you forged links and support with those doctors who were almost living there?

DR BLETCHER: Well firstly to say that, you know I think obviously doctors who lived in the townships often had even a much worse situation than we did, because at least at times we were able to escape from the difficulties of work and recover outside whereas a lot of doctors and health workers who worked in the township faced the same stress at night as they did during the day.

I must say organisations like the Namda Support Group for Doctors, Emergency Service Group for Doctors were really helpful at the time in supporting doctors around the country who were trying in their way to respond. I think there is no question that in these most difficult and dark times there have been incredible contributions by the health workers around the country, by a number of health workers around the country in the face of a profession which was largely silent.

MS MKHIZE: Just one last question. I get an impression that you were hospital-based at that time when you were exposed to these atrocities, is that correct?

DR BLETCHER: Well in Crossroads we worked for an NGO clinic, the Empelisweni SACLA Clinic was an NGO clinic. In Duncan Village, yes, I was employed by the Province of the Eastern Cape, so that

was a State employment. But then in the evenings we opened this detainee service as a kind of NGO detainee service outside our State employment.

MS MKHIZE: The reason why I asked whether you were attached to a hospital at all is because what you are describing is difficult to comprehend as to - I mean you do mention that there was complete silence but were there any efforts to put pressure, even within a local hospital where you were based where maybe often you had doctors' meetings, maybe on a weekly basis, to talk about what you were exposed to?

DR BLETCHER: In the Eastern Cape almost nothing, as I say, except for the Namda doctors group which we had. Now that Namda doctors group was a very supportive environment. It was an environment where those few doctors who were committed could share experiences and kind-of realise they weren't crazy or something like that. But inside the official State structures there was absolutely nothing on that.

CHAIRPERSON: Thank you very much. Pumla?

MS GOBODO-MADIKIZELA: Everyone is staring at me because I raised my hand. Dr Wendy Orr my apologies, just one question. The South African Medical Journal is the publication of the professional association of medicine, is it?

DR BLETCHER: Yes.

MS GOBODO-MADIKIZELA: I am interested to know, often when you send in an article for publication you get responses from reviewers, what were the comments of the reviewers on your article?

DR BLETCHER: Very few comments were given. Basically they felt that the article was not of the kind of academic standard that they would want in the journal. Now looking back at that with some hindsight, and having now published over 20 articles in referee journals and so on, I think there is no question that it was one of our earlier you know attempts, and it wasn't a particularly high-falluting academic article. But the - you know the response that we had was just so impersonal and so - there was absolutely no support and didn't say, why don't you put this as a letter because you are describing something which is of relevance to South African medicine, or as an opinion or look we've published the following ten articles in this area and therefore we are not publishing it. It was just part of the general silence in the time.

Just another example which I wold like to briefly give because you asked the question about was there an opportunity to voice some of these things. I remember one event in the Department of Commu-

nity Health, University of Cape Town where the Department of Community Health attempted to bring to light some of these events and they held an epidemiology seminar describing all the injuries and one forensic doctor told about all the people he had seen who were shot and so on. Now I remember one particular presentation by a senior forensic colleague and he spoke for about 45 minutes about the number of cars that had been burnt out, and a number of buildings that had been damaged, and the number of this that the other - that was all I can remember for that length of that speech and it went on for quite a long time. That was the kind of response that.....

MS GOBODO-MADIKIZELA: Thank you.

CHAIRPERSON: Thank you very much. We just want to say that we are glad there are young people like yourself and others around. And we are here now. Thank you.

EXPERIENCES AT ACADEMIC INSTITUTIONS

DR WENDY ORR: We are going to hear next from two doctors who were students at the University - one doctor at the University of Natal and the other at UCT, and they are - I've called him Professor Solly Ratemane but he tells me he's not a professor yet but I have promoted him, and Dr Ahmed Moosa. Could both of you come up please.

Welcome Dr Moosa and I will continue to call you Professor Ratemane. Fazel is going to be leading the evidence from you Solly and Glenda from Dr Moosa. DR RANDERA: Gentlemen in the interest of time can I ask you both to stand to take the oath.

SOLLY RATEMANE: (sworn states)

AHMED MOOSA: (sworn states)

DR RANDERA: Solly can I just introduce you first. You are a consultant psychiatrist at Medunsa in the Garankuwa Hospital and you are also head of the Child and Adolescence Psychiatric Unit since June 1996. You've come to talk to us about your experiences as a medical student, firstly at the University of Natal Medical School where you did your undergraduate work, and then later at Wits Medical School where you did your postgraduate work.

PROF RATEMANE: Yes.

DR RANDERA: Please take your time and tell us what happened.

PROF RATEMANE: Thank you. I would like to thank the Commission for allowing us to ventilate on some of our experiences at various institutions of learning. I think issues of concern today cannot be complete without a statement of the experiences of medical students at various institutions, and I think I was particularly asked to talk about my experiences as a Black student at these universities, and I will do so without any apology.

I want to preamble my submission with a quote from Reverend Martin Luther King Jnr, and I quote,

> "But hatred and bitterness never cured a disease of fear, only love can do that. Hatred paralyses life, love releases it. Hatred confuses life, love harmonises it. Hatred darkens life, love illuminates it".

I really want to refer back to this quote in Reverend King's work many times in my presentation because I think these institutions, University of Natal and Wits University had both good and bad people. The good people, unfortunately, could not be seen very clearly because they were absorbed in a system that was imposed on them by the government of the day. One would look at that as complacency, that some of them were accomplices to the perpetuation of apartheid in learning institutions. However, it appears that on global analysis that some of the good people who reacted to racist practices of the day were paralysed by this fear that Reverend King mentions in his works, and I think that fear still continues today.

We have since this morning had apologies about mentioning of names. That still means we are afraid to be specific about our contributions because we think this would lead to certain consequences.

I hope that what the Commission can do for us is to help us unleash that fear and enable us to talk openly without fear, but we may end up in jail as we did in the past.

With regard to the University of Natal let me start by indicating that I made a decision to study medicine whilst at Morris Isaacson High School in Soweto. I lived in the township of Naledi which is in Deep Soweto. It was a logical thing for me that the nearest university for me would be Witwatersrand University. If I could not get money for accommodation at the student residence I would stay at home and use public transportation to and from the University on a daily basis.

On enquiring about such studies at Wits the first response was that I needed to get permission from

the Minister to attend at this university as a Black student. Even when I passed the Joint Matriculation Board examinations with a first class pass this did not help the situation as the university had to oblige by government ruling that Black students needed the relevant permit to study at Wits.

We were encouraged to apply to the University of Natal as the State would give us bursaries payable by service to or in State institutions upon qualifying. Many other students with good passes at Matric were similarly referred to other universities which were thought to be suitable for Blacks for various reasons.

Briefly stated my studies at the University of Natal were not a matter of choice but an act driven by the racism of institutions such as Wits in those days. And again one poses the question, was it really Wits or the government of the day? And was then active response from academics in these institutions to deal with this kind of discrimination.

Despite having passed very well in Matric on arrival at the University of Natal I was informed that I had to do the preliminary year in order to learn practical English and be given a better background in physics, chemistry and biology. There was no screening to determine whether I needed this bridging course or not. I felt insulted as I had always done very well in these subjects but had no choice as this was the only institution that would allow me to study medicine. This was indeed a waste of time but did not happen for White students even if they were weak in the sciences.

I also recognised, upon arrival at the University of Natal, that almost all the top positions, in terms of senior lecturers and professors were occupied by White teachers. This did some negative thing for me in terms of role modelling. One did not immediately have access to good role models, and it seemed as though any effort Black doctors made they were always relegated to inferior positions in spite of the fact that this faculty was established to train Black students in medicine. This situation changed although a little bit since I started studying there.

Our accommodation consisted of neglected soldiers barracks modified into students dormitories. This was at the foot of an oil refinery which daily emitted fumes that could be harmful to our health. Also only Black students lived in this residence. The White students were accommodated in a more humane environment near the main campus of the University of Natal. This we viewed as an instance of racism that was corrected many years after some of us had left the University. These barracks could not be

improved in any way to make them more habitable. Who could we blame for this? The University for its complacency or the government for apartheid? These questions need to be revisited.

In 1977, for some of us, was a turning point in terms of our attitude to the University of Natal. We were informed that the government wanted to phase out African students from the medical faculty and train Indian and White students only in the future. The Whites in Natal complained that their children were not allowed to train at this medical faculty and that the government deemed it fit to phase out Black African students. We were also informed that the Black students were lucky that they had Medunsa, that is the Medical University of South Africa, all to themselves.

In denouncing the racism related to this intended move we argued back and pointed to the imbalances in terms of the number of Black doctors compared to White doctors in South Africa. In this context we believed that Medunsa should be a welcome addition rather than a replacement of the training available to Blacks in medicine. The University reacted very little to this. They accepted this measure, and under pressure from the Students Representative Council the University was able to take this matter back to government and this was taken finally to Parliament.

We had a strong feeling that some of the senior White members of the University were in total agreement with this move. The mild protest from Black lecturers was ignored as they had no power in this institution. The student body stopped classes to deal with this matter. I personally tabled the motion, seconded by Dr Jack Mpafuri, to the effect that we are going on an indefinite boycott of classes until this move was nullified. This motion was carried unanimously and we planned an intensive national mobilisation in support of our protest.

As I pointed out this matter was finally taken to Parliament and only then was this abominable decision temporarily reversed. We still had the suspicion, which could not be tested at the time, that this evil intention would still be carried out, however, in a very subtle manner. Indeed, as I speak now, most Black African students have been referred to Medunsa for medical training, some were not admitted. There is a very small percentage of such students at the University of Natal.

Also senior Black lecturers could not be given professorships at the University, and much against their will some of them moved eventually to places such as Medunsa where they could be accorded some respect as human beings and also as teachers. The University of Natal must still be revisited with regard

to this matter.

At this stage I think a rift has been created between Indians and Africans by giving top positions to Indian lecturers and ignoring African lecturers. I know that there are all efforts to normalise the situation but we are still not happy. One hopes that the current transformation in the health sector will look at such issues in terms of who occupies which posts. I strongly believe that some people are in these positions by default and not by merit. Who do we blame, apartheid government or institutional racism?

In closing on this subject I need to mention that some of us will find it difficult to forgive the University of Natal for complicity in driving away Black African students, including Black teachers from this University. Our anger around this issue was so intense that many of us boycotted graduation at this University. I know that my class did so, the class before us and a few classes after us. There was a feeling of a loss. We could not associate ourselves with the University.

Later there were attempts at reconciliation but we thought this simply touched the surface and we think this matter must still be reexamined.

At this University in the same year I was detained at the beginning of September 1977 and placed in solitary confinement for 14 days, and it was a chilling experience to me that one of the landmarks of my detention was a morning in solitary confinement in a very small cell when a colonel came in and said, do you know that your leader is dead? We killed him. And the leader referred to was Steve Biko. It was interesting how the death of Steve has impacted on many of us in different ways, and that it was even used to torture us in detention.

It seemed no one knew where I had disappeared to and some students even thought I was on holiday. I had been picked up from my room at 2 a.m. by the Security Police, driven to a police station in Durban and later to the one in Pietermaritzburg where I was interrogated about my possible knowledge of PAC recruitment drive of youth for military training.

Without personalising this issue as it happened to many of us, my concern was how easy it was for the Security Police to enter our residences, fetch and arrest students without a word to or from the University. One could die in jail without one's family knowing. The University claimed not to know of our whereabouts, however, we also had a strong feeling, and believed that some senior members of the University did know, and they were informed by the Police, but they were asked to keep quiet about their

detention without trial and other forms of humiliation at the hands of the Security Police. Who again do we blame, these individuals, the University or the Government? These questions must still be answered.

Our negative experiences at this University do not imply that we did not have moments of bliss and moments of passion about our condition as human beings, however, many of us could come up with other stories that merely shattered our confidence or eroded our egos. Many students survived these onslaughts and tapped their inner resilience to conquer (...indistinct) and afford some moment of happiness, and I think this is an issue about those of us who survived.

I will briefly state two or three points related to my training at Wits, and again I need to refer back to the initial opening remark that I think many individuals at these institutions were paralysed by the fear to react to the racism of the day that was really fully manipulated and regulated by the government of the day.

I had no difficulty in being admitted to specialise in psychiatry at Wits. This would be the first attempt to train Blacks in this field and so I posed as a natural experimental subject. I encouraged Dr Thabo Ranaka to join me in this venture and he obliged. We already knew some aspects of the overt and covert racism at Wits and so we did not have a problem in agreeing to support each other in this journey. We also wanted to function as students of psychiatry uninterested in the problems of the University as a whole. However, certain experiences forced us to write letters and speak about issues that made us unhappy as they interfered with our training. If these issues were common to all students, Black and White, most probably our approach would have been different.

On scrutiny we realised that we had problems far different from our White colleagues in the same field of study. It became clear that such problems would not arise in their case because they were White and the University gave priority to their training needs.

Some examples included difficulties to get seniors to supervise us every day, so we were left on our own. We had to be primarily on our own and hope for the best. It took more than a year to get the Professor of Psychiatry to visit the hospital where we were placed for training. It took another year to convince the department that it would help to rotate ward rounds so that our colleagues could understand the conditions under which we were trained and also capture the thin support system available to us.

This we argued would also help them understand the nature of mental diseases in the Black com-

munity as we were concerned that Black people were easily and glibly being diagnosed as schizophrenic or having problems of substance abuse, mainly alcohol and dagga. Some of the problems were resolved as we raised them but our concern was so deep that Dr Ranaka made arrangements to complete his post-graduate studies at Medunsa as he noticed that we were being neglected. He was never given the necessary transfer to Medunsa and against his will he completed at Wits. It seems the issue there was to add and emphasise the fact that Wits also trains Blacks in psychiatry.

As part of our training in psychiatry we also had to do neurology. Our lecturers in clinical work took place at the Wits Department of Neurology. All seemed to go well in terms of the patients we were allowed to examine until one afternoon when Dr Ranaka and I were the only two postgraduate students who attended the clinical session. The senior specialist would not give us a patient to assess. We were told that she was protecting us against embarrassment if the White patients were to refuse to be examined by Black doctors. It was clear that we were only allowed to examine these patients in the presence of our White colleagues who would explain that we are also doctors.

On raising this matter with the psychiatry professor he was duly upset and tried to get clarification. We do not know what he was told but it never happened again.

Of interest is that a White colleague was sent to us by the same specialist who could not give us patients to examine, and these were White patients, to ask us if we came to Wits to study or to raise political storms. We did not have problems answering him as we noted that we have examined and offered advice to many White patients and they were happy with us as doctors.

It appears that the racism was in the mind of the particular specialist in neurology. And I want to emphasise that because the Institution itself had clearly made a case against racism and it apparently was individuals within these institutions who felt that they were custodians of certain principles but indirectly or unwittingly they perpetuated apartheid in the training atmosphere.

I close my submission on Wits by noting that it was in many ways difficult to know whether to blame isolated individuals, who were insensitive to our needs as Black students, or perhaps one should have directed the blame to the University as an accomplice in perpetuation of apartheid in this atmosphere. For instance I do not know whether I should blame the Department of Psychiatry and even the individual in this department or the University for denying us a training in child psychiatry.

I was allocated a rotation in this placement at TMI, which is one of the White centres providing training for our Department in Child and Adolescence Psychiatry, on the eve of my commencement at this centre a senior member of the Department of Psychiatry phoned me to inform me that I will not be going to that centre as the superintendent of the centre was White and racist and he was not happy to have Black doctors interview White children and White families. My anger at my Department and the University was immeasurable.

I resisted completing my studies in psychiatry without this important training, hence I applied for a scholarship with the British Council to do an intensive postgraduate training in Child and Adolescence Psychiatry in London at the Institute of Psychiatry. Of interest is that as soon as one was placed there we saw everybody. You were not given Black patients because you were a Black doctor, you were given patients as they came. You were treated as a human being and the atmosphere was wonderful and one was able to complete the training with distinctions.

This was a success story for me and it clearly demonstrated that where there is a will there is a way. Who do I really blame for this denial to learn? Who discussed the matter with the superintendent about a Black coming to see White children and White families? What was the context of this discussion and who started it? I did not allow anger and hatred to paralyse me but I proceeded to accomplish my goals, be it at great sacrifice to my personal and family life.

One knows not how many other Black doctors, who were discouraged by this subtle atmosphere of discrimination who could not therefore complete their postgraduate training and who also disassociated themselves with these institutions. I believe, therefore, that it is very, very important that whoever is involved in the transformation in the health sector, particularly looking at academic complexes, should take the needs of all students into consideration. I think those Universities that are training both Black and White students must make a conscious effort not to just pay lip service to the fact that they are training so many Black students and so on. They must go a further mile to say how do we empower ourselves to understand the needs of these Black students and what kind of mental preparation do we have. Because I want to believe that as we are going through and have gone through some reconciliation with some of the senior members of staff at Wits and also at the University of Natal, it became clear to me that they didn't understand that their frame of mind was more informed by apartheid ruling and that it was

governed or driven by apartheid.

I don't think it is going to be an easy thing simply for them to say we are training so many Blacks, but there must be workshops, there must be training, there must be an effective practical process to help them to empower themselves in understanding the needs of all students without discrimination. Thank you.

DR RANDERA: Solly thank you very much. You've referred to the attitudes of medical schools and of course raise the question of institutionalised racism, can you tell us about any direct links that you may have had as a Black student, Black doctor with the Medical Association of South Africa or the South African Medical and Dental Council and their responses to the training of Black doctors in South Africa?

DR RATEMANE: The issues about our training had been sent to the South African Medical and Dental Council and there was no response. And I think we saw our training as occurring in the context of developments in South Africa and issues such as the response of the Council to the death of Steve Biko made us very unhappy, we could not trust the Council to help us in this process.

I want to raise the fact that international organisations were even more helpful in supporting us. I know that in 1986 the American - the Triple A S asked us to talk about this issue of training of science within the apartheid situation. It was very clear to us that you couldn't develop human beings fully within the apartheid situation because of the limitations engendered by racism and discrimination at various levels.

Internally, in short, it was difficult to survive within those institutions. Survival was enhanced by attaching oneself to community organisations, community health workers' groups and later on to structures such as NAMDA. But within the formal structures, MASA, Medical and Dental Council we had no hope that we could get any assistance.

DR RANDERA: Solly one last question, and I want to actually just move slightly away from your presentation if I may and use your expertise as a psychiatrist. We've heard the stories of hundreds of people and taken statements from thousands of people, the impression one is sometimes left with in dealing with the stories, and especially the torture stories that we've heard, that psychologists and psychiatrists may have played a part in the training of the custodians of these police cells, do you have any knowledge of this? Would you want to make a comment on this?

DR RATEMANE: I think one's comments would be related to direct and indirect situations, namely that as people came out of detention with various psychological problems, severe depressions, some being totally out of touch with reality, in short they were psychotic. There was a pattern of diagnosis at some of our institutions whereby there was an active resistance to see detention without trial and torture as a stressor. That could precipitate their presenting a psychological problem. It would be as though the person was prone to depression, the person was prone to schizophrenia, despite any evidence from family history and so on.

The case in mind is a young student who was studying at the University of the North, Turfloop, who went to university to do first year in BA, very healthy. There was a student uprising in the middle of the year. She was beaten by the police and held in detention. She was later admitted to Hillbrow Hospital during my training with some confusion, with some problems in walking and so on. We did a CAT scan which showed some small haemorrhage in the brain. The report from the radiographer was that it was most probably TB. There was no evidence of TB anywhere.

On emphasising that the only stressor, the only trauma that she sustained was at the hands of the police, I was asked a question and again here fear paralysed me from continuing further in this inquiry, I was asked whether I have done a proper differential and whether TB wouldn't cause the same lesion. Yes TB could cause the same lesion but there was no evidence of TB. This lady died a week after admission, and TB would not kill her that precipitously. Now this was a psychotic colleague who was dissuading me from insisting that this problem was as a result of the beatings, the head injuries suffered when the police beat this young lady.

There were a number of people admitted diagnosed as depression, but if you look at our scale of classification in terms of diagnosis one of the axis there says what are the psychosocial stresses, many of our colleagues would not mention detention without trial, or police interrogation or torture as a form of stressor. It would be as though the stressor is only the political activism and political activism itself it's not a stressor, it's something that people do with passion and they are prepared to die for that.

MS WILDSCHUT: It's my responsibility to invite you, Dr Moosa to do your presentation and then we will do a round-up at the end. Please go ahead. Are you going to be using the.....

DR AHMED MOOSA: I am going to be using the overheads and my colleague is going to project for me.

MS WILDSCHUT: Yes.

DR A MOOSA: Archbishop and Commissioners, thank you. Thank you for allowing me to make this presentation. I have a few documents which will form the basis of my oral submission to the Health Committee of the TRC and this submission is made in my personal capacity.

I am of the opinion that this information should be brought to the attention of the Health and Human Rights Professionals Accountability Project and thank you once again for allowing me to talk to you today.

We've heard Professor Solly here talking about training during the seventies. I am going to take you back a little earlier. I entered Medical School in 1958 and I am going to reflect on the medical training that we had during the 1960's, the late 1950's, 1960's and these are my personal recollections.

At the time, I don't need to remind the Commission of the apartheid climate at the time, but there was a total onslaught on human dignity at the time and there was a separation of virtually all amenities, services, governmental departments, recreational facilities and this extended into the universities. Our career choices at the time were very, very limited, not because the faculties were necessarily closed but because of post-qualification limitation in work opportunities. So most people who went to university at that particular time had one of three choices. They became teachers, they became lawyers or they became doctors.

What was university life - I was at a White liberal university at the time, what was university life like at that particular time in the late fifties and the early sixties? The first thing that greeted you is the fact that there were no African students. Now I make no apologies here for talking about people in terms of their colour and their race because these were the classifications that were used at the time. There were no African students on the UCT campus. The only African people working there were people who were employed as labourers and as assistants maybe in some of the laboratories.

There was an unofficial quota system at the time. It was never really spoken of but it was obvious there was an unofficial quota system at the time because the figures for admission into first year medicine were always very much the same. They were always in the region of about 20%. In our first year group

there were two ladies of colour in our first year group, in first year medicine, in 1957/58, just two, just two female admissions.

Some of the social aspects on the campus that greeted you first of all is that all the residences were closed. You couldn't stay on the campus no matter where you lived, no matter where you had to come from you had to travel by segregated public transport, buses, trains. The clubs on the - all academic or social clubs on the universities were closed. The societies, you couldn't really become members of them because they were mostly in-house sort of things. There were sports facilities but those were segregated. There was a Rag, the Annual Rag for example, the sum total of your contribution was that you were allowed to sell the Rag magazine on the streets but you couldn't participate in any of the student involvement in the Rag. In short there was a total lack of integration on the campus.

This lack of integration continued throughout our medical school years. There was an unwritten law that things should be separate. In anatomy in the second year of study, in the anatomy laboratory we were separated into a smaller lab. All the students, all the Black students were separated into a smaller lab.

In third year the autopsies that we attended, the post-mortems that we attended, they would only show Black bodies if there was a mixed class. If there was a White corpse that had an interesting pathology these corpses were eviscerated in an ante-room and the organs from these bodies were brought in and displayed to the class. You weren't even allowed to see a White corpse.

Ward separation in the hospitals was complete. Groote Schuur hospital, which was where we trained, was separated by an invisible line, and one side of the line was a total no-go area.

The staff complement at the academic teaching hospitals was all White. There were no lecturers of colour, both at Groote Schuur and at Red Cross. At the smaller new Somerset Hospital, which is in Green Point there were people in training there who were some of our lecturers and some of our registrars.

At the time it seemed, either through paralysis, as Professor Solly here has said, or whether this was an extension of the general perviation of the apartheid system, the professorial attitudes, the attitudes of the lecturers, the attitudes of the students, no one really stood up and said hey, why is it that 20% of this class is not allowed to participate in all of the activities, all the academic activities, all the social activities of the rest?

There were exceptions. There were exceptions, there were people who were prepared to stand up for us, people who were prepared to mix with us socially, people who took us into their homes, and here the people who stood out - Dr Raymond Hoffenberg, who went on, later became a real thorn in the side of the government, so much so that he was banned under the Suppression of Communism Act, had to leave this country on an exit visa, went on to become the President of the Royal College of Physicians in England. A very, very prestigious post. This is how they could sacrifice a man like Professor Raymond Hoffenberg.

Ralph Gurr was a surgeon who also left the country despondent, became a surgeon who rather went to continue working in the States, the United States. Dr Saunders at the time too was a man who stood up for us at that particular time.

I don't need to remind the Commission of the political climate at the time but political organisations were all banned. The ANC was banned in 1960. There was very little public participation in political activity.

During our clinical years, which is the years when the students enter the hospitals and when they are trained in the hospitals, the tutorial groups that we were in were separated along colour lines. This was to facilitate those of us who had to go in residence for example at the time when you do midwifery, when you do obstetrics, we couldn't go and deliver, we couldn't work in the White wards in the obstetric wards. So the tutorial groups at a very early stage were separated along colour lines. As I have said the White side of the hospital was a no-go area for students of colour. One couldn't, for example, join a ward round, sometimes there were these grand ward rounds at which the professors would be shown problem cases and they would go from one side of the hospital to the other and we were never allowed to go on the other side. The other 80% of the students could do that.

When we qualified we found that internship posts were very, very limited. The only hospital in the Cape, in the Cape Peninsula rather that would take us, was the new Somerset Hospital, and that had a very small complement. It is probably not an accident the fact that they could only take about 15 doctors there, it was probably not an accident that only 15 or 20 students were admitted into the first year.

The separation of doctors continued throughout our internship years. There were separate residences for the few - there were three or four White interns with us. They had a separate dining room.

There was obviously the very sore point of differential salaries.

If one went on to postgraduate training at the time that was also separated. Those who chose to do postgraduate training found that if they were training at the Somerset Hospital they had no access to training, for example, at Groote Schuur or Red Cross. There was no access for them to the grand ward rounds, as I've mentioned, on the White side of the hospitals. They had no access to the special clinics at Red Cross Hospital so they couldn't do a full rotation through cardiology and allergy and dermatology and such things, as the other trainees did.

Postgraduate scholarships sometimes had to be given up because no posts were available at medical schools. Students who had gained scholarships, for example, and wanted to pursue a line of study which entailed them to enrol at an academic teaching hospital found that they would have to give up their scholarships. Many graduates were forced then to go overseas to pursue their studies. Most of them never unfortunately returned, and those who did return found that suitable placement in hospitals became very problematic because they were not given the sort of posts that they deserved, they were offered junior posts, they were told to do their training all over again and that sort of thing.

For those who went into private practice we found we couldn't practice where we wanted to. We were forced into the ghettos. There were further restrictions on Indians who couldn't practice in areas which were not designated as Indian designated areas.

In the early 1960's students were required to seek permits from, I think the Home Affairs Department, if they wished to study at the White universities. This permit was granted on an annual basis, it had to be renewed annually. Specialists who chose to practice in the medical centres also required to apply for permits to practice in those centres. Similarly other health workers experienced similar problems and difficulties.

Just to remind the Commission, Professor Solly has already mentioned, in 1975 there was the threat to close Natal Medical School to Africans because they were building Medunsa.

In 1976 there was a similar threat to close UCT Medical School to Indians and Coloureds and there was talk of having a separate medical school, based possibly at the University of Western Cape.

A watershed year Steve Biko's death and the inactivity, the total incompetence and inactivity of the Medical Association and the Medical Council to do anything about the death of Steve Biko.

In 1978 Medunsa was created and Medunsa was eventually inaugurated then to cater for medical training of Africans.

If the Commission can just indulge me for a while I want to show some figures which will graphically demonstrate how entrance into universities was a very, very ....

If we look at acceptance in first year medicine in 1981, these are figures which come from the South African Institute of Race Relations in 1982, if we take them by University and then look at the population groups. In 1981 Pretoria admitted 220 White students only. Wits you can see the similar preponderance of White students with a scattering of students of colour. The Free State was similarly all White. UCT was almost all White. Natal, which was the only medical school at the time to admit Indians and Africans obviously had no other students there. Stellenbosch was almost completely lily White. Medunsa, which had then come into being and was taking its third or fourth year of intake had 40 African students and five. Out of a total then of 824 students who were admitted into first year medicine in 1981, something like 80% of them were White and 20% were students of Colour.

In 1980 the doctors who qualified the figures show the same sort of preponderance. If we again take it these are doctors then who qualified in 1980 per university. Pretoria was 169 White doctors; Wits 176 as opposed to 15; Free State 61 Whites only; Natal, as we have said before, Indians and Africans; Stellenbosch all White, 114 and UCT 137 White with 21 students of Colour. Again out of a total of 657 graduates in the year of 1980 only 19.9% were students of Colour, or rather were graduates of Colour.

This sort of bias continues if one looks at the enroled dental students for the years 1979 - 1980. Out of a total of 942 enroled students 12% only were students of Colour. That means 88% of dentists who were going to be trained in those particular years 88% were White.

The figures become even more alarming if one looks at the number of pharmacists. In 1976 there were 51 Coloured pharmacists and 122 Indian pharmacists. In 1973 only two Africans were allowed to qualify as pharmacists and there were 12 registered African pharmacists only in the country as opposed to 4,693 White pharmacists. The source is the same, SAIRR.

This continued even with our nursing colleagues. The population group here shown, African, White, African, Coloured, Indian, and out of a total of 55,000 close on to 60% were White. These were White registered nurses, these are nursing sisters. About 60% of them were White.

I've presented these really just as a reflection of things which I experienced and things which I remembered as a result of my training and my later passage through into the medical world. Thank you.

MS WILDSCHUT: Thank you very much Dr Ahmed Moosa. Could we please just hear from you before we close your presentation, what you are currently doing and what's your current status at the moment?

DR A MOOSA: I am a family physician. I am in private practice and in a partnership where I have been for the past almost 30 years.

MS WILDSCHUT: Thank you very much. Thank you very much for your submission. I do not have any questions. I will hand over to the Chair in case any of my colleagues would like to ask some questions.

DR WENDY ORR: I think I am the Chair by default as the Archbishop has had to leave us. Are there any further questions? Hlengiwe.

MS MKHIZE: Just one quick question from me maybe to the two of you, do you think there's a link between what you have just described and the complete inability on the part of our health workers to empathise with people who were murdered, shot at, teargassed by the police? By saying a link being the fact that people were products of a system which was discriminatory and racist so to say.

DR A MOOSA: Yes I have very little doubt that the system of apartheid was so pernicious that it affected everybody to a greater or lesser extent, so much so that either through, as I have said before, either through paralysis or either because they were so much part of the system and afraid to make any submission or rather any action or to commit any action which was different from that of what they were expected to do, that a lot of them found that they were more-or-less frozen in what they did and continued doing the sort of things that they felt most comfortable with.

It took exceptional people, and as we have heard earlier from the young doctor, Dr Bletcher, it took exceptional people to recognise that what was happening to a certain section, to the majority of people in this country, was not only a Black problem it was a political problem.

PROF RATEMANE: I just also want to add that various periods of history teach us different things. For instance our acute awareness about the post-traumatic stress disorder in this country is only very recent. And as the Commission started its work and we heard the cries of people, their reactions to various things, I think more and more of us, that is people in the Black, not in the Black but in the health sector generally, were more educated about the effects of those atrocities. But it raises the question of whether we are

prepared as a country to help to deal with the after effects, long term effects, of those atrocities. I think this is where institutions of training, such as universities and so on, should collaborate with NGOs in developing structures, that can provide help to those who suffered in those days, and then maybe in that process we can engender that sense of empathy.

DR RAMASHALA: I'm thinking about how to phrase this question, but let me come out and get the benefit of your thinking about what seems like a grand scheme which was pervasive throughout South African society and the attempt to, perhaps not annihilate Black people, in particular Africans, as we can see systematic killing of Black people; refusal of any kinds of opportunity for Black people, in particular African people, as if it's a grand scheme to keep African people in a certain position, so-to-speak, as servants throughout the whole society, what is your thinking about this? And I am just asking you to reflect about what just seems like generalised annihilation of Black people in our society with specific targeting on African people.

PROF RATEMANE: I personally think that that statement is appropriate and it was the given within apartheid rule, that was the intention. However, human beings of all kinds are very resilient and one can never annihilate them completely. I think it was also important that one recognised, through various interactions with Black and White colleagues, Black and White friends, that not all people within the so-called White group were party to that active attempt to annihilate the ego, the persona of the African people, that there are people who realised that co-existence was possible and to live well together we need to understand each other, we need to begin to understand each other's backgrounds and so on. And I think these are some of the good people that one referred to earlier on who felt there should be some operations to try and protect our being collectively as a nation, not just as a White or Black group.

But I think one sees a very quick process towards achieving that goal post-independence where suddenly many people are able to say what they can say openly. Their minds are free. Though people cannot all achieve much materially but they are free to express their views and they have limitless opportunities where possible they can reach out and intensify themselves, or empower themselves in different ways.

I think that grand scheme has failed and I don't think we will ever have that kind of scheme again in this country and we shouldn't allow it to happen.

DR RAMASHALA: Chairperson may I ask that perhaps, as an extension of this hearing, that you give us the benefit of your thinking in writing about the reform of institutions that we may redress, but more importantly to ensure that this never, ever happens again. If you could give us the benefit of your thinking, in writing, and send it to Ms Hlengiwe Mkhize, the Chairperson of the Committee on Reparation and Rehabilitation, we would very much appreciate that.

DR WENDY ORR: One last question from Ms Pumla Gobodo-Madikizela.

MS GOBODO-MADIKIZELA: Thank you Dr Orr. Dr Ramashala I think, benefit of thinking right but I think in the final analysis benefit of action is necessary because I think that the consequences of the colonisation of everyday life by apartheid still exists today. The majority of people who are not White in this country are still living in squalor of poverty and lack of quality in their lives.

But what I really wanted to say is that you both, Ahmed and Solly, have reminded us of the burden of being Black in White institutions during a time when affirmative action for Whites was practised in this country. And Solly you mentioned in your presentation that you thought that in White institutions there should be a focus on Black students and what their needs are and how they are coping, etc. But first I think that focus should be balanced with a focus on White students who have also gone through the socialisation system in this country, to also address the problems that they face in being thrown in situations where they suddenly have to face the reality of non-racialism, of integration in their institution. I think that there should be a balance and institutions should focus more on creating this balance rather than focusing on Blacks as a focus, as a study so-to-speak. I think it has happened on both sides.

You are right, we have to celebrate those individuals in these institutions who have stuck their necks out in the bad old days to support Black students, to fight for human rights for all, and they stand out as examples for us and perhaps we could tap the experiences that we've had, this country has seen of people, White people who have stuck their necks out in times which were hard and where it was difficult to stand out and speak out. Thank you Madam Chair.

DR WENDY ORR: If I may abuse my position as the Chair and say Solly that as you were presenting and talking about the kinds of unusual diagnosis that were made on Black patients, that were made on Black patients who were in solitary confinement, again as I had access to files in the Department of Justice, I looked at the file of one detainee who had been kept in solitary confinement for many months and was

showing severe stress and was diagnosed in 1986 by a district surgeon as having "Bantu hysteria", which I am sure has never appeared in DSM Classification whatsoever. Thank you very much to both of you for coming and sharing your experiences. We will be continuing this exploration of academic institutions when we hear perhaps a different side of the story when people from UND, Wits and the University of Pretoria will be making submissions. Thank you very much.

DR WENDY ORR: I would like to announce that the Medical Association of South Africa has very graciously and kindly agreed to defer their submission to tomorrow morning so that we can perhaps catch up with ourselves a little bit. I asked them if they would do this, not in any way out of disrespect or discourtesy, but because we feel that their submission is very important and I think people have had a long day and are tired and if we had to continue until six or seven we wouldn't be able to do credit to those submissions which we still have to hear. But this does mean that we start at 08H30 tomorrow morning, not at nine o'clock as advertised.

A DOCTOR WHO RESISTED

I'd like to move on now to a presentation by Professor Frances Ames, whom we are greatly honoured to have with us today. She is a stalwart of resistance to human rights abuses and standing up for human rights of patients and we really do welcome her most warmly to our hearings. Frances, Dr Mapula Ramashala will be leading your evidence.

PROFESSOR FRANCES AMES: (sworn states)

DR RAMASHALA: Professor Ames good afternoon. It is indeed refreshing to see a woman as one of the presenters. One might think by seeing blue suits and white ties that this war was fought only be men. May I express my appreciation that you also will be presenting, not so much as a woman, let's not high-light that, but as a participant on the right side of the war. Please proceed.

PROF F AMES: I am surprised at your surprise because we both belong to the largest group of oppressed people in the world. (General laughter). So we should identify more readily with the suffering.

Thank you for letting me speak. I am one of the six doctors out of a total of about 15,000 registered medical practitioners who, in 1984, obtained an order from the Transvaal Supreme Court compelling the South African Medical and Dental Council to discipline the district surgeons who had been accused of improper and disgraceful conduct in the medical management of the death in detention of Steve Bantu Biko, aged 30 years. This doesn't mean that other doctors were not concerned. They were but they were reluctant to take the final drastic step of going to the Supreme Court.

My own personal involvement in the Biko saga began in June 1980, almost three years after he had died. Like the MASA, which is the trade union of doctors, I had abdicated responsibility for medical ethics to the South African Medical and Dental Council and seldom even bothered to exercise my vote for some of the members of this powerful statutory body.

Biko was the 46th political detainee to die in imprison. We had omitted to act in the face of all these deaths because of our unquestioning acceptance of the authority and integrity of the South African Medical and Dental Council whose stated function was to protect patients from improper or negligent medical conduct.

The only members of our profession who had access to prisoners were district surgeons who were often poorly trained and believed that their primary responsibility was not to their patients but to the Security Police. The South African Medical and Dental Council had not corrected this erroneous impression, so there was undoubted ambiguity about their role.

Until 1980 I was unaware of these facts, until I was pushed and shamed into action by UCT students. They invited me to join a panel to address a public meeting held at the Medical School to protest against the refusal of the South African Medical and Dental Council to discipline Drs Lang and Tucker who had been accused of improper and disgraceful conduct during the public inquest into Biko's death.

I accepted their invitation and was surprised when some hours before the meeting I was summoned by the Superintendent of Groote Schuur Hospital. He told me that head office had phoned him to tell me that I was a provincial servant and forbidden to participate in political activities.

My account of this interview, fortified by Burke's memorable comment, "that for evil to succeed

it is sufficient for good men to be silent", received wide publicity and committed me to five years of intermittent struggle.

The Press pursued the Biko affair relentlessly. It would have been quite impossible for any individuals to have done this and to have mobilised effective public indignation.

Further threats from head office followed. They were always verbal, usually telephonic, and related to dismissal from my job. Every effort was made to avoid depicting me in a favourable light by the Press.

About this time a group of us from UCT and Wits, having taken legal advice on how we could act, met to discuss strategy. To my astonishment my colleagues, all male, decided not to pursue the matter because it was not considered ethical to crucify our colleagues. Sympathy for the district surgeons in their ambiguous situation was expressed. I was confused by this development which seemed to indicate that it was more important for the medical profession to close ranks than to protect the health of detainees.

Further defection of sympathisers followed later, predominantly because of financial concern about our legal costs. Eventually two groups decided to pursue the matter. It was unfortunate that there were two groups, but these finally amalgamated in our submission to the Supreme Court.

In February 1982 we lodged our two separate complaints requesting the Council to hold a full, proper and preferably public inquiry. The group to which I belonged paid our attorney about R6 000 to draft our petition. We waited over a year before the South African Medical and Dental Council replied rejecting both petitions. We realised at this stage that if we were going to be involved in further legal costs we would have to be more practical about the situation. Professors Jenkins, Tobias and I requested donations from sympathetic colleagues by personal letters. Bill Hoffenberg, who had been forced to emigrate to the UK because of the severe restrictions placed on his academic career, appealed in a British Medical Journal for financial support for us. The South African Press regarded this as news and published it. Eventually about 20% of our total funding came from overseas and we had about 34, R35 000.

Two advocates, Mr Sydney Kentridge and Dr D P de Villiers offered us their services pro amico. Namda, an organisation formed in 1982 to represent health workers, encouraged their members, of which I was one, to support us financially. The MASA, to which I also belonged at that time, did not. And when

I happened to meet the President of the World Medical Association, who was visiting South Africa, I asked him whether he did not agree that the MASA should contribute to the fund, he said that no medical association in the world would challenge a statutory body such as the South African Medical and Dental Council.

The overseas funds were not released to us for some time because we were accused of having violated the Fundraising Act.

In 1980, because of our disillusionment with the South African Medical and Dental Council, some of us at UCT and Wits realised the need for establishing local ethical medical committees which could offer immediate advice and support to doctors and have faculty status. We wrote to the other five medical schools suggesting this, none of them replied.

The UCT ethical body was named the Professional Standards Committee chaired by the Dean, had five faculty members and two student members. A major achievement of this body was to badger the MASA to examine the ethical issues arising from the medical care of detainees and to organise their submission of their ad hoc committee.

The students were concerned about the rule that when they graduated they would swear an oath which included a clause to the effect that they would treat all race groups equally. So they brought this problem to the Professional Standards Committee for discussion, and we ruled that it was correct to drop it.

After a year of serving on this Committee I was dropped and apparently rumour had it that this had been organised. You couldn't rely on Frances Ames to behave like a gentleman!!! (General laughter)

When we, much to our surprise, when we won our case in the Supreme Court we were left with R34 000 which we divided between the two medical ethical committees.

In November 1984 the Supreme Court ruled that the Inquiry Committee and Medical Council had failed to apply its mind properly at all to the Biko affair and ordered them to discipline the doctors.

So during July 1985, almost eight years after Biko's death, a disciplinary committee of the Council charged the two doctors with disgraceful and improper conduct. Dr Lang was cautioned and reprimanded. Dr Tucker was initially suspended for three months, later removed from the role of practitioners and later still reinstated.

The South African Medical and Dental Council remained graceless throughout. The doctors received virtually token punishment for serious offences. It never apologised or admitted guilt and indeed it was rumoured that it planned to take the case to the Appeal Court. Although the extreme generosity of our two advocates had relieved them of paying their costs they refused to pay the airfare of Dr de Villiers who had had to fly from Cape Town for the trial.

In their final issue before they disbanded, which was published in November 1994, the South African Medical and Dental Council congratulated itself on its proud record of service.

I have been asked to reply specifically to several questions.

How did I feel about blowing the whistle on colleagues? Obviously I didn't enjoy this. All of us saw the Medical Council as the chief culprit, but we were unable to deal with their guilt without approaching it through reviving the case against the doctors.

I was particularly upset that Dr Hirsch and Mr Keeley, neither of whom I thought had behaved unprofessionally, also had to be included in our submission because there had been some discrepancy in the evidence given by the doctors. This doesn't mean that I approve of doctors closing ranks. I condemn it vigorously. Doctors should see themselves as primarily serving patients and not their fellow doctors.

Another question was, **what support or lack of support did we get from various bodies like UCT and the Medical Faculty and what domestic support did I get**?

UCT supported us in encouragement and advice and finance, but did not join us in appealing to the Supreme Court. Some members of the Medical Faculty supported us, others derided us and some made strenuous attempts to stop me personally, on the grounds that I was damaging UCT Medical School. Students gave virtually unqualified support.

My mother supported me but stipulated that I should not spend any money on the battle on the grounds that that money should be kept for my boys - (general laughter). For a widow with four sons this was a consideration, but I disobeyed this maternal injunction.

Some of my own sons were concerned about my safety, advised me strongly never speak to the relatives of detainees or other people on the phone because it was almost certainly bugged. I had acquired the reputation of being the prisoners' friend so was subjected to many inquiries and appeals.

Was I victimised?

Probably, but I have no hard evidence for this.

Did we think we would win?

I certainly didn't and I think the fact that we were advised to have two advocates indicated the reluctance of our legal advisors to really encourage us that we would be successful. Once of course we had won we acquired many friends. Nothing succeeds like success, but I am sure if we had failed we would have been ridiculed and derided by many people.

Did this take a lot of time?

It took an immense amount of time, and that of our secretarial staff. Professor Jenkins' secretary meticulously kept a record of all donors and the amount donated and kept both our local and our overseas funding separately. Constant discussion between ourselves, our lawyers and the Press fragmented our time. Our post was interfered with. On one occasion a registered letter sent to Mr Kentridge disappeared for six weeks.

What are the memories that stand out?

My main one was the discovery of the extent of submissiveness to authority. An alarming number of people were prepared to obey orders from the authorities and to jettison principles. This is of course is not unique to South Africa, or unique to the medical profession. One of the most constant excuses for the Nazi and other atrocities was that individuals were only obeying orders.

I was ruefully confronted with my own Achilles Heel. I reacted with terror at the possibility of punishment for stepping out of line when my third son, who was doing his army service, telephoned me to say he was being posted to Angola. The possibility that he might be deliberately exposed to danger because of his mother unnerved me.

The other memory that stands out is my dismay and surprise that senior colleagues could, at one stage, refuse to pursue the fight because of their reluctance to crucify their colleagues and their feeling that they should close ranks.

What are my recommendations for safeguarding behaviour in the health profession in the future?

I think preventing submission to authority and absolving oneself from blame by saying that one has to obey orders is widespread. It starts in childhood in the second year. I have been encouraging my

grandchildren, every time they challenge their parents to be rewarded. (General laughter). Perhaps it's not surprising that their parents have emigrated. (More laughter).

I think all medical students should be taught about the research on submissiveness being a key etiological factor in the perpetuation of atrocities. They should be fully familiar with Milgrim's work and reflect on Hannah Ahrens Concept of the Banality of Evil. I would certainly restrict the power of every senior member of the Medical Faculty and restrict administrative power by the Heads of Departments. Students should have effective representation at every level and should serve on every single committee. Historically students are always in the vanguard of progress.

The Professional Standards Committee should become a vibrant force at the Medical School. None of its meetings should be held **"in camera"**. There should be a lawyer on the Committee. Medical doctors are the most ignorant of all professionals outside their own narrow field. And the Committee should liaise freely with the Press.

I think that prisoners are the most badly treated and vulnerable of all our patients, and the doctors who serve them should be properly trained, especially in neuro-psychiatry and should receive status and adequate remuneration. Their work and prison activity in general should of course be open to scrutiny.

Do I regret the stand I took?

No. I learnt a great deal and don't regret it, even the suffering that it's inherent in all important learning. I do, however, wish we had achieved more. The exposure of the tarnished image of our noble profession damaged our reputation profoundly. We can only regain it by wholehearted commitment to minister to the health needs of all South African students both now and in the future.

<u>DR RAMASHALA</u>: Thank you Professor Ames. I have, in the interests of time, I have a few questions, maybe two. Much has been said about the condition, I'll call it, the condition of poor training of district surgeons, perhaps even forensics as mentioned by the other presenters. Is it really just a question of poor training? Could it also be, or have been a subjugation of professionalism to the political ideology of the day, first?

Second, you mention that, and I quote,

> "All medical students should be taught about human rights...."

and I think that's probably a paraphrase. There are two critical issues that come out of this. One, the

district surgeons of the past continue in their assignments. If we follow the argument, they are still poorly trained. There is something very frightening about their continuation if we have not done any corrective measures and in effect the rehabilitation of district surgeons.

The second is, if we agree that all medical students should be trained, or should be taught about human rights, taught by whom? By the very professors who perpetrated discriminatory practices? I mean this is a very serious question that I am asking. Who teaches the teachers of the medical students?

Should in fact all medical doctors, regardless of whether they were perpetrators, so to speak, or not, in fact should this whole society be rehabilitated so that we all start from scratch? What is your thinking about that?

PROF F AMES: I think all the factors that you have mentioned about the collusion of the district surgeons with the Security Police and various other factors, their fear, their submissiveness are all true. But then on the other hand the Security Police certainly didn't want Biko to die. They knew that there would be an international outcry and they summoned the doctors nine times in three days, so that there was inefficiency at a clinical level. But then the recognition that they were inefficient, so that they strongly advised that he should be hospitalised and receive specialist treatment, but then they yielded to the Security Police once they refused that, and didn't make a point of it. So I think all these factors are important.

DR RAMASHALA: Thank you very much. To you Chairperson.

DR WENDY ORR: I am afraid I am going to have to, and I am glad Professor Ames is supporting me in being autocratic from the Chair, in that one of our next witnesses has to leave at 16H30 so we do have to move on. So I am not going to allow any further questioning. But thank you very much Professor Ames for being here.

SYSTEMIC ABUSE

DR WENDY ORR: I am going to ask Dr Leslie London and the witnesses who are accompanying him to come up to the table next. Their evidence will be facilitated by Ms Pumla Gobodo-Madikizela.

MS GOBODO-MADIKIZELA: Good afternoon to you Ladies and Gentleman. Thank you for coming

at this point of the submissions. Welcome to you Miss Ncanywa and Mr Nel and to you Dr London. Thank you very much. Before we start I will ask Miss Glenda Wildschut to swear you in.

LESLIE LONDON: (sworn states)

BETTY NCANYWA: (sworn states)

JACOB NEL: (sworn states)

MS GOBODO-MADIKIZELA: Thank you Glenda, and I am Pumla Gobodo-Madikizela. Leslie I think you are going to give a brief introduction. Thank you.

DR L LONDON: Yes. Thank you to the Commission for this opportunity. This session is looking at complicity of health professionals in systemic abuses. And I think we have heard quite a lot about how services in the past have been discriminatory. I think the purposes of this session how health services, both in the public and private sector, were complicit, not just in the sense of providing discriminatory or racist health care, but were coopted into the security agendas of the apartheid state.

I have asked Mr Jacob Nel, who is a resident from Zolani in Ashton, who has travelled in this morning for two hours to be here, to tell his story. And Mrs Betty Ncanywa, who unfortunately has to catch a flight at 5:30 which is why we are under time pressure. So I am not really going to introduce them other than just to ask them
to speak. Unfortunately Betty will have to leave and I doubt she'll have time to answer any questions. But Betty will speak first and then Mr Nel and then I will put in some summaring comments.

MS GOBODO-MADIKIZELA: Please go ahead Betty. Thank you Leslie.

MS B NCANYWA: Thank you Madam Chair. I would like to take this opportunity to thank the TRC for awarding us this opportunity, as well as the organisers, the Health and Human Rights Project who made this day possible for us to share some of our experiences during the period of 1985/86 while I was working at Livingstone Hospital in the Eastern Cape where the many atrocities occurred, Livingstone being the only Black hospital that was catering for the victims, because some hospitals were only treating White patients. There are cases from the seventies but I will be focusing more on the cases that I was directly involved in.

Most of the cases that we attended were gunshots and tortured burns and patients with severe

depression. Most victims were children, youth, adults, males and females. Some died before they reached us. Some died on arrival. Some were taken before we could treat them, the Security Police would take them from the casualty department before we can even treat them.

The casualty department and the operating theatres were very overcrowded and very busy and casualty was full of blood those days. As nurses we were given an instruction that we mustn't obstruct the work of the security force. We mustn't stand in the way of the police. The only thing we need to do is to just treat the patient. Even if we see people being tortured we must just keep quiet. This was the instruction from the hospital management.

At some stage we were also asked - we were obstructed from visiting the political patients, as well as we were asked not to talk to them. And we mustn't allow their families or visitors to them.

I remember I was also called aside by my supervisor because of my involvement with Namda, distributing some document, trying to conscientise the nurses, I was called aside that the higher authorities were discussing me, so I must try to refrain from politics otherwise my future would be in jeopardy.

One of the clients that I came across was Emson Banda, which was in the papers for many years and he was very depressed. At that time I was working in casualty. Then I tried to talk to him aside and I talked to the police to leave us alone, and then the guard was very nice and he left, because Emson was refusing to talk to people. He covered his head, but later on he gained confidence and then he said to me please, I lie, I said I overdosed myself with tablets because I wanted to get into hospital. Is it possible for you to get me admitted, just to get relief, even if it's one day, because we are being tortured in the cells.

So luckily there were progressive doctors in our team which I convinced and we tried to discuss how we can get Emson admitted. Then we had to phone the head of department, Pat Naidoo, who was the head of the Department of Medicine at that time, so he gave us instructions from that evening we must admit all political detainees, whether they are cases or not. And some of them there was no evidence of torture because of the system that was used to torture them. So all of those wouldn't have symptoms, they were given a common diagnosis, that is severe depression.

Gunshot patients were kept in a separate slate in casualty. This was the instruction from the matrons. And then that slate was taken to the matron's office and then they usually take the names of the people who were shot to a police officer who was situated next to casualty in a caravan. And then that

police officer would liaise with the Security Police and then those cases would be immediately guarded. After treatment he would be taken to jail irrespective who shot them.

As I mentioned some were taken even before they got treatment. There were cases who were constantly coming to the hospital, like the MEC today of Safety and Security, Dennis (...indistinct) who would come with fractured arms, swollen faces and scars in his face. There were many of them who are leaders today, like Sceros Uplan(?), Nkosile Jack, Sizani and Brian Sokuta and some of the students from Dower College. I remember Donovan. And they were kept in the wards and the police would come to the ward without talking to the ward sisters whenever they felt like taking the patient, irrespective of the condition of the patient they will just grab that patient and take them back to the jail. And sometimes they confiscate the equipment that has been ordered by the doctor for occupational therapy just in front of us. They were not allowed even to read papers whatever.

Sometimes when they are bringing the victims, sometimes they escort one patient you find that more than ten policemen would come to the casualty department and then at that stage the casualty department was very small, and then they would come with big guns and keep fingers on the triggers and walking around terrifying the sick patient and children. And sometimes they made our lives so difficult to work in casualty. And then when you beg them to leave just few people and stay away they would just ignore us.

It was a very traumatic experience those days. Even if you were not working in casualty you would make a point that every day you pass casualty. Sometimes I came across my own relatives and my own brother who was shot.

I remember one evening there was a 16 year-old boy who was brought by the police, mishandled, his leg was hanging loosely, badly shot, and I remember Dr Brendan from Australia he couldn't take it that evening. We were very, very busy, the casualty was very overcrowded, and he asked them, why are you killing the innocent people? What are you going to say in front of court? Why don't you finish your work? Why are you bringing to us? One day God will answer their prayers. And South Africa is full of blood and injustices, and I am leaving this country, and he really resigned during that period.

Dr Naidoo, we were working together in the Medicine Department. He was threatened by the security forces, by the authority, the Medical Superintendent. We will make these documents available

and the people that we implicated because I don't want to mention their names in case we are in trouble, but we are going to submit them. He was called several times, threatened with dismissal. He was also threatened to appear before the Disciplinary Council.

And he also wrote to the Medical and Dental Council to report the ethical behaviour in the hospital. And then the letter we still keep - we've got the letter. The response from the Medical Council was that there are two sets of ethical conducts. One that is subscribed by the Council, and one that was subscribed by the state of emergency, so we had to comply with those ethical conducts.

At that time as nurses we felt that we had violated some of the rights of the patients because we were redirecting the patient not to go to the hospital. We removed bullets, we referred some of them to the Namda doctors and some of the hospital doctors who used to work after hours and help the patients. We also removed bullets but those complicated cases we referred to the GP's in the township. And we were wondering where is the Medical Council. Where is the South African Nursing Council who are supposed to protect the public, but they were not visible. There is nothing they did during that time.

I still remember when we battled, Dr Naidoo - there was a psychiatrist who was collaborating with the Security, who removed Brian Tsikudu from the Medical Ward to a mental institution, Elizabeth Donkin Hospital, and Dr Naidoo battled so much to get him back.

Some doctors we used to see them in casspirs with guns and you see them in labour wards. I still remember when they were mishandling our patients, being so rough to our patients, and one I think that day he forgot to remove his soldiers' boots, he came with those boots on duty, and he was so rude to the patient and I confronted him and I asked him, is it you that I saw in the casspir? But he didn't answer me. I believe he was from the Free State. But there were many of them who were seen by some of my colleagues.

I hope some of my colleagues will come to the TRC and raise these issues, especially the matrons who were directly involved, to share these experiences and tell the nation what was happening those days, so that we don't repeat those mistakes in future.

I would like to thank the Namda doctors who were there for us. And then some of the White doctors were very supportive to our people during those days. I thank you.

MS GOBODO-MADIKIZELA: Thank you very much Betty. I understand you are rushing for time, but

I just want to say that the rupture of silence is often a very painful experience and it is obvious that there are ruins all over your memory as you have shown us this afternoon. Betty, I just need to ask one question. In relation to the management who decreed that you should cooperate with the police, who was management? Can you just explain to us who management was?

MS B NCANYWA: It was the matrons and medical superintendent.

MS GOBODO-MADIKIZELA: The matron and medical superintendent at Livingstone Hospital.

MS B NCANYWA: Yes, yes.

MS GOBODO-MADIKIZELA: So was there a meeting to inform you on this rule? How was this information communicated to you?

MS B NCANYWA: They usually have a matrons' meeting and then our supervisors would come every morning, every morning there were staff meetings and it's where these things were communicated to us. And then they would also go directly to the units that were directly involved, like the casualty unit, also the medical wards.

MS GOBODO-MADIKIZELA: Thank you very much Betty. I do not want to delay you any further.

DR WENDY ORR: From the Chair thank you very much. Certainly what you have said about PE in those days has brought back memories for me too.

MS GOBODO-MADIKIZELA: Leslie can you proceed please.

DR L LONDON: If I could just really say that the examples that Betty gave were not isolated to one particular area. I think we have heard from Mark this morning
and we've had many other stories of other hospitals where similar events took place, and it wasn't an isolated event.

Just to summarise many hospitals saw situations where medical records were seized as a result of which people might be detained or information was used in interrogation. People who arrived at hospitals were routinely arrested, and we know that in Cape Town for instance, one of our teaching hospitals, Groote Schuur Hospital, the situation was such that medical students set up their own safe house in Observatory. They were subsequently reported by the hospital authorities to the University and their house was placed under Security surveillance afterwards.

We've had many reports of detainees being shackled, being examined in the presence of security forces, and that clinical decisions, as Betty described, were often dictated by security interests.

But we want to make the point that it wasn't only public sector services, that the fabric, well apartheid permeated the whole fabric of the health services and it was also in the private sector, particularly in rural areas where many of the GPs also worked as part-time district surgeons. Some of the stories that the TRC has heard have often involved GPs who were part-time district surgeons, often working in situations where practices were racist and separate, that's why we've asked Mr Nel, who has kindly come through from Zilani to talk about his experiences. It's a small rural town about two hours from Cape Town and he's going to describe his experience in relation to a private general practitioner in the town.

MS GOBODO-MADIKIZELA: We greet you Sir.

MR J NEL: I would also like to greet the Truth Commission.

MS GOBODO-MADIKIZELA: We thank you for coming forward.

MR J NEL: I would also like to thank you for the opportunity to come before the Commission.

MS GOBODO-MADIKIZELA: Can you please tell us your story as it was already said.

MR J NEL: I will start in 1986, although I cannot remember the date. There was a funeral in Ashton then and on the evening of that day all these casspirs arrived full of policemen with doctors and everyone and they went to stop at my house. The police had balaclavas over their heads, all of them. They came into my house and when they came in they were looking for vigilantes. They were looking for one particular person amongst - one particular child of mine. This child that came into my house said look dad here are the police, and when I went to the side where the police were the police came in in police uniform and balaclavas on and one doctor came in with them. A doctor from Ashton.

There were eight of them altogether with two vigilantes. The one vigilante was behind the door. At the same time this child had in the meantime slipped out on the other side of the house, and then when they came in they decided to take this child that was at home, that had just been discharged from hospital, that was still ill, and I refused. These four Boers who were standing to my left, the others were standing there, one threatened to shoot me with his gun. I then went to him and took his gun away from him. When I did that another policeman assaulted me, hit me on the head. He was standing next to this doctor who was there.

MS GOBODO-MADIKIZELA: Could you please explain this doctor, is it a practising doctor there in your area?

MR J NEL: Yes it was a doctor who had his own surgery who would treat us all for whatever our ailments were, be it high blood pressure or sugar diabetes, or whatever, us as workers of Langeberg factory, and he came in in police uniform as well with a balaclava over his head as well. He is present now that I am talking to you. He is right here. Although he has since left us there he is in Paarl. I am just mentioning that he is here.

MS GOBODO-MADIKIZELA: You may proceed.

MR J NEL: Thereafter the police assaulted me there in the house and threw me to the ground and my wife picked me up. When she did they took her and pushed her through one of the doors in my house and closed her up in a room there and then they dragged me outside.

When I got outside there was a policeman who did not have a balaclava on. His face was clearly visible, and I asked him what are you doing now, and they said no, he should go as well, and he said you did not say you were here to fetch him, you said that you were here to fetch the child, but now you are taking him as well. Leave him. And then they left me.

I was full of blood on the one side of my body and I opened my garage to come out, to bring my car out so that I could go to the doctor, and when I was going to leave this policeman who had said to me that I should stop everything, said to me that I should just stop everything, leave everything and I left the car. And he said to me there were no doctors. And I could see that there was this one who was amongst them. I do not know how many others there were because there weren't that many of them. That's all I have to say.

MS GOBODO-MADIKIZELA: Thank you very much Sir. The essence of your version here today is that amongst those people who came to threaten you and terrorise you there was a doctor in their midst?

MR J NEL: Yes.

MS GOBODO-MADIKIZELA: I just want us to ascertain do we agree that you said that you were not going to mention his name because there is a problem with people being implicated here today, but I would like you to explain to us, did you see this doctor with a balaclava on?

MR J NEL: The balaclava slipped off his face and I saw his face. I know him since 1980 - I haven't seen

him since 1987/88, but I've seen him here today and I still recognise him.

MS GOBODO-MADIKIZELA: Did you ever speak to him after this incident?

MR J NEL: No I have never spoken to him since. I never ever went to him again.

MS GOBODO-MADIKIZELA: The people in the area in Zulani, do they know him?

MR J NEL: They all know him.

MS GOBODO-MADIKIZELA: Do they know him as being someone who worked with the police from time-to-time?

MR J NEL: Yes there were those who knew that he was one of them on that night.

MS GOBODO-MADIKIZELA: I am now going to hand you back to the Chairperson. I do not have any more questions which I would like to put to you, but I am sure that my fellow panellists would like to put some questions to you. I will ask Leslie if he has anything to say. Leslie do you want to make some concluding comments before I pass you on to the Chair?

DR L LONDON: I would like to conclude just with some recommendations, some issues which arise out of this. It was obviously not only public sector services but the whole of the health sector that seemed to imbibe this attitude towards complicity with security.

We also want to make the point that there were health administrators who facilitated the operation of military security structures, the Joint Management Committees that effectively took control of many of these rural areas. So the problem was very far-reaching and really permeated the whole structure of the health sector.

I want to say that there are certain things which would need to be done and this list is not definitive, but there are some issues which we feel the TRC should consider as recommendations to prevent this happening again.

We believe that all health facilities, whether private or public, should have policies that protect doctor/patient confidentiality, clinical independence and establish institutional independence and accountability, as well as promoting patient advocacy, because these are cases where doctors were not acting as advocates for the patients except in the cases that Betty was describing.

We would also support a charter of patients' rights that would be developed and driven by a

process which patients or clients or communities are central.

And that health facilities should have effective ombudspersons who would be accountable to, for instance, with the new structures of hospital boards, have greater community input and the protection of human rights of patients as the priority.

Lastly, we believe that there's a great deal of documentation that hospitals and many health professionals are sitting with that should be made available to the TRC in terms of memoranda and other papers which demonstrate the extent to which there was complicity in a systematic way between the institutions and the security forces.

I will end there.

MS GOBODO-MADIKIZELA: Thank you Leslie. Just a comment from me. One of the things I've found incredible throughout these hearings, not only this particular hearing, is how the State and the organs of the State appropriated, controlled and monopolised violence. I think it's been clear that there has been violence perpetrated by other political groups, but I think it's striking the way in which the State monopolised forms of violence through it's control of opposition in communities in creating opposition or fostering opposition in communities and denying services, important medical services to certain communities. I find that quite incredible.

Thank you Leslie and thanks to you too Sir. I am now going to hand back to the Chairperson.

DR WENDY ORR: Thank you Pumla. Perhaps if I could just comment on the issue of naming of names, because I would hate the audience to think that the TRC is entering into the culture and collusion of silence.

A number of doctors were named in submissions which were sent to us but unfortunately a number of them had very common names so we had great difficulty locating those doctors and sending them their Section 30 notice as required of us by the Appellate Division decision. However, we now have sent all those notices out but the doctors have to be given adequate time to respond.

Once that procedure has been followed and the doctors have responded or have been given a chance to make representation we will pursue the matter either by referring doctors to the appropriate disciplinary bodies or by releasing the names. It's just that we are not able to do so at the moment because it would be in contempt of court if we did so. And that is the reason why we have asked people not to

name names, not because we are trying to protect or hide any particular individual.

Does anyone else have any questions? Thank you Leslie. Thank you Mr Nel. And a safe journey home. Thank you very much for coming.

MR J NEL: Thank you.

S A M D C SUBMISSION

DR WENDY ORR: We are now going to move directly into the submissions by the South African Medical and Dental Council and then the South African Medical Services and we are going to re-arrange tomorrow's programme to fit in those people who we have not been able to hear today.

So I would like to ask the representatives of the South African Medical and Dental Council to come up to the table. I believe it's Dr Becker and Mr Prinsloo.

Thank you gentlemen, welcome, you've had a long day and a long wait. Thank you for bearing with us and your patience. Dr Fazel Randera will be facilitating your evidence.

DR RANDERA: Dr Becker, Mr Prinsloo good afternoon. Before I ask you to take the oath, let me just as a way of introduction put both of you in context. Dr Becker and Mr Prinsloo of course, you are here representing the new Interim Medical and Dental Council.

Dr Becker you have a past president of the South African Medical and Dental Council and in fact sat on the Council from 1980 and presently still sit on the Council.

Mr Prinsloo you have been working for the South African Medical and Dental Council since 1965, and if I remember rightly you have been the Registrar of the Council since 1980.

You've heard a great many things said today about, not only the Council, our health services, the Medical Association of South Africa and I am sure you have many things to say in response.

LEN BECKER: (sworn states)

NICO PRINSLOO: (sworn states)

DR RANDERA: Dr Becker are you going to start.

DR BECKER: Thank you Dr Randera. I would just like to apologise on behalf of the President of the

Interim Council, Professor Karachiram who has had to leave the proceedings because she has other commitments elsewhere.

We have prepared a submission to the Commission which the Commission has received. However, I think many of the people that are here today have not had insight into this submission, and I thought it would be wise to inform them of the contents of that submission. So I will ask Mr Prinsloo to briefly go through that. I don't think he needs to read the whole thing, but if he could just mention the most important aspects of that submission to the Commission.

MR PRINSLOO: Thank you. On behalf of the Interim National Medical and Dental Council of South Africa we thank you for the opportunity of making this submission.

I will just highlight certain of the matters raised in the memorandum to put it in perspective, and by way of introduction to say that although I have been with the Council for a long time I do not have personal knowledge of all of these matters. Some of these have been extracted from the documents and the minutes of the Council.

The Interim Council was established in 1995 to replace the South African Medical and Dental Council, the SAMDC, the Ciskei and the Transkei Councils, and this deals more specifically with the SAMDC, not the other two Councils.

The Council in its submission says that the activities of the SAMDC must be looked at having regard to the objects of the Council as stated in the Medical Dental Act. And those are to assist in the promotion of the health of the population of the Republic; to exercise control over training and professional conduct; and to advise the Minister.

The Council says that it should be noted that it does not directly render medical or health services or have jurisdiction in matters pertaining to that.

Now although created by statute originally in 1928, the SAMDC was not an organ of the State. It was totally funded by the health care professionals falling within its jurisdiction. The majority of its membership was persons who were not appointed by the Minister. We give you the breakdown of the actual membership of the Council.

The SAMDC was created by Parliament to perform the functions assigned to it by the law that

created it and the Council functioned within the framework of the laws governing the country at the time.

The members of the Interim Council who are also members of, who were members of the SAMDC state that they are unaware of decisions taken by the Council or its predecessors having regard to the fact that members are elected or appointed for five year terms, that they are unaware of any decision which wilfully discriminated on the basis of race, gender, culture, religion or any other consideration.

The Council, however, states that merely functioning within the law when one knows full well that some of those laws are discriminatory in nature and not going on record in opposition thereto does not withstand the scrutiny that the conduct of the regulatory body of health professionals should be able to withstand.

The Council dealt with certain general matters and certain of those have been listed, not as an exclusive list, but to give some indication of what the Council did and what the Council didn't do.

In relation to the education and training facilities and medicine based on race, in 1957/58 the SAMDC was made aware of the proposed separal Universities Education Bill. And although invited to submit evidence the Council did not take a stance on this matter.

In relation to separate hospital facilities based on race, according to the minutes this was never formally discussed and no action was taken in this regard by the SAMDC.

In regard to medical treatment of terrorists. Following an enquiry from a Regional Health Authority the Council in 1979 resolved that the medical treatment of a so-called terrorist remained compulsory but in those cases the authorities must be advised of the circumstances.

The Council, also in relation to the treatment of prisoners in detention in 1980 resolved to convey its concern to the Minister of Health with regard to the apparent deficiencies which appeared to exist in the facilities and staffing of health service to prisoners and detainees.

After interviews with the Ministers of Justice and Law and Order in October 1985 the Council decided that it was of the view that a practitioner treating prisoners and detainees should render the appropriate generally accepted medical assistance, and if he or she was not able to do this, for instance because the patient was removed from his care, or if his prescribed treatment was not adhered to, he should protest, indicate the condition of the patient and the probable consequences of such action and bring the matter to the attention of the district surgeon or regional health director or director of hospital

services.

Also in 1985 the SAMDC appointed an ad hoc committee to investigate existing legislation relating to the medical treatment of persons in detention. The Committee had great difficulty in obtaining from the Department of Health its guidelines to district surgeons on the treatment of detainees.

It also had great difficulty in meeting with representatives of the South African Police. Eventually this meeting did take place and as a result of this and subsequent meetings the Council recommended to the Department of Health that a consolidated document be issued giving clear guidelines as to the treatment by district surgeons. Such a document was subsequently issued by the Department of Health.

In relation to the treatment of patients of different race groups and separate waiting rooms the Council only in 1989 adopted a policy that it was not acceptable to discriminate on the basis of these facilities in relation to different population groups.

Then some specific matters have been mentioned. The obvious one being the one of Drs Lang and Tucker which relate to the death of Mr Biko. There has been reference earlier about this, but perhaps just from the Council's perspective to put the chronology in perspective.

In December 1977 the ombudsman of the South African Council of Churches lodged a complaint against the doctors concerned arising from the treatment of Mr Biko. The magistrate in January 1978 referred the inquest record to the Council.

In terms of the regulations of Council the doctors concerned were asked for explanations of their conduct in March 1978. In response, the attorneys acting on behalf of these two doctors, objected and indicated that the request wasn't in accordance with the regulations in terms of which complaints had to comply, and also requesting that the matter be postponed pending the civil action to be instituted by the Biko family.

In September 1978 the executive committee of the SAMDC decided that the matter be not held over pending the civil action and also informing the doctors concerned that they should furnish their explanations and if they didn't want to do so they should approach the Supreme Court, which they did.

It then took more than a year for the matter to be heard by the court, and the court eventually in December 1979 dismissed the application of the doctors.

The Council then repeated its request for the explanations in December 1979. The attorneys on

behalf of these doctors advised that their attitude unaltered, and they did not render an explanation. The subsequent meeting of the Committee of Preliminary Inquiry of the SAMDC which is the Committee which deals with complaints initially and must decide whether there should be a formal inquiry or not, that Committee on the 24th of April 1980 considered the matter and also had before it opinions, one from a general practitioner and one from a neurologist, requested by the Committee. That Committee decided that the documents be noted and that no further action be taken.

Some members of the Council then requested that a special meeting of the SAMDC be held. This took place in June 1980 when the decision of that Committee of Preliminary Inquiry was confirmed.

In February 1982 the SAMDC received further complaints against these two doctors as well as two further doctors mentioned earlier. The Council at that time obtained legal opinion regarding the situation and was advised that unless new evidence was submitted regarding the specific complaint the Council was not in a position to reopen or to rescind its previous decision.

In March 1983 the Committee of Preliminary Inquiry decided that as all material evidence had previously been submitted no further action be taken.

The complainants then took the matter to court and this was held, and eventually in January 1985 the Supreme Court ruled that the SAMDC should hold an inquiry. This inquiry was then held in July 1985.

After this inquiry the Council did in fact debate the possibility of taking that decision on appeal and was advised that in law in fact the Council had a reasonable prospect of succeeding, but nevertheless the Council then proceeded with the inquiry in July 1985.

The one doctor was found guilty of improper conduct and cautioned and reprimanded. The other one was suspended and at a subsequent meeting of the Council in October 1985 that was changed to an erasure from the register.

Perhaps very briefly, just to contrast this with the case of Dr Mkwapi(?), because in that case it's been stated that the Council did not display the reluctance to hold an inquiry as it did in the previous case.

This doctor was registered as an intern in July 1974. He was then convicted in terms of the Terrorism Act and at some stage the Commissioner of Police informed the SAMDC of this and enquired whether the Council was going to take action. He was advised that as Dr Mkwapi was not registered at

that time the Council did not have jurisdiction, but should he apply at a future date for the restoration of his name the matter would be looked into. And that happened in 1983 when the Committee of Preliminary Inquiry decided that an inquiry be held. That inquiry was held in February 1985 and at the hearing he was found not guilty.

The Council raises the question and attempts to answer it and hopefully this may assist the Commission, and the question is why was there this apathy on behalf of the SAMDC to campaign actively against clear cases of social injustice? The answer as implied above lies probably in the fact that the SAMDC functioned in a society of which virtually every member of the politically dominant group was steeped in doctrine and propaganda. The SAMDC did not act in the way it did because of direct State involvement, since government appointed members were in the distinct minority. It probably acted in this way because of the milieu in which it functioned.

Then the Council recently, in relation to a response from Dr Orr, decided that it could not agree to any amnesty in respect of professional conduct of registered health professions in respect of any contravention.

As far as the future is concerned, the Interim Council obviously cannot bind future Councils, it can only express the sincere hope that politically inspired acts or omissions on the part of future Councils will not be tolerated by the majority of men and women who serve on those Councils. In this regard possibly the autonomy, the independence of a body like the Council would be very important.

In conclusion the Council again records its appreciation for the opportunity to appear before the Commission. It trusts that the submission will contribute towards clarifying the actions or inactions of the past, that it will promote the healing process and that it will assist in building trust and understanding between health professionals and the public.

DR RANDERA: Thank you Mr Prinsloo. If I can just start off by asking a few questions Sir of both of you. This morning we have heard a great deal and it's often about what happened to Mr Biko. Can you explain to us how it's possible that two different inquiries under the auspices of the same body could reach such diverse conclusions, i.e. that the Committee of Preliminary Inquiry in 1980 said no further action should be taken, and then in 1985 those doctors were reprimanded and one of them was actually charged with disgraceful conduct?

DR BECKER: Thank you Chairman. The position is that, as Mr Prinsloo explained, that the initial handling of a complaint by the Council is done by a Committee of Preliminary Inquiry. That Committee consisted of some Council members and some outside members. In this instance these members availed themselves of, as Mr Prinsloo mentioned, the opinion of outside independent practitioners who had access to the evidence, the court record etc. And on the strength of what they received from the court records and on the information they received from these practitioners that Committee came to the conclusion that no further action should be taken.

However, when eventually the inquiry was held, that was a completely different body in a different Council. Remember the Council's terms of office stretch in five year terms, or used to. So that was - one Council from 1980 to 1985 and then new Council from 1985 onwards. So that when eventually this inquiry reached the stage where it came before Council there was a completely new Council with new members, and that Council then came to the conclusion that the practitioners were in fact guilty.

I do not find it such a strange occurrence because I think this is something which happens in our courts quite often, that people will appeal against the sentence and a senior judge will come to a different conclusion as to what was the decision taken by a lower court. Peoples' opinions and peoples' perspectives of what has happened will sometimes differ.

I would just like to mention, whilst I am dealing with this case, and the punishment that was meted out to Dr Tucker, it was mentioned here earlier today that very mild punishments were decided on for these people. Of course the Council has got no heavier penalty than to strike a person's name off the register, and that was done in the case of Dr Tucker.

In the case of Dr Lang the law at the time specified that if somebody is cautioned and reprimanded by a Disciplinary Committee the Council itself could not change that finding or that penalty, and therefore in the case of Dr Lang, it's (...indistinct) that I cannot say whether the Council would have changed it if they had the powers to do so. But those are the facts of the matter at the time.

DR RANDERA: Dr Becker can I just come to the question of detainees.

DR BECKER: I didn't hear that.

DR RANDERA: I just want to come to the question of detainees, and the Council's response over a period of time. In your own submission you say that in 1985 an ad hoc committee was formed. Clearly if

we look at the period that we are examining, 1960 to 1994 the first person to die in detention was someone called Luks Martin Gudle(?) in 1963 in the Pretoria Central Prison. Many others have died subsequently. In fact at the inquest held into the death of Ahmed Timol the magistrate recommended that district surgeons examine people very carefully during the time that they are in prison.

The Council seems to have taken a long time. I mean given that your objective, one of your objectives is to do with - in the promotion of the health of the population of the Republic, the Council seems to have taken a great deal of time responding to this particular situation. Would you like to comment on that?

DR BECKER: Yes. One of the weaknesses that we have in our system is that the Council has not got a force of, a police force or an inspection force to go around and to evaluate situations in prisons or in hospitals or wherever. Council reacts to submissions made to them or complaints lodged with Council.

So I can start off firstly with the mention of the persons, the names you've mentioned, I don't know about those cases, and whether they were in fact ever reported to Council. I am not sure that those deaths in detention were associated with medical treatment of prisoners, or whether those were simply a case of torture etc by police. However, Mr Prinsloo should be able to give us some information if he has that, of whether those cases were reported to Council.

However, to come back then to the question you asked that the Council took a long time to react. That is correct. Council did not react timeously and should have been aware from Press reports or from other sources about what was happening with detainees.

However, as Mr Prinsloo has said, the Council has for a long time been somewhat confined in its view of its own activities in that the Act specifies the Council should maintain standards of education and standards of conduct of practitioners, and the others are sort-of attached to that, and the Council concerned itself mainly with those two aspects of the activities. And that is a shortcoming, we admit that. Council should have been more pro-active in that respect.

Perhaps we could ask Mr Prinsloo if he has any information regarding the persons you have mentioned.

MR PRINSLOO: I couldn't establish from the Council's records that those cases were referred to Coun-

cil.

DR RANDERA: Dr Becker observers have said that institutes, organisations played significant roles in the production and reproduction of apartheid, I don't want you to answer a question relating to that, but I want to go back to a submission made by the Nationalist Party. The Nationalist Party talk about different phases in their development and actually talk about 1978 as being the beginning of a period of reform. We've seen and heard today from Dr Ratemane, Dr Moosa, how few Black professionals were trained in this country. I know in your submission you say that when the Act was passed in 1957 you were asked to make comments but you did not do so.

Can we hear from you whether there was, given that there was this reform taking place in the social milieu that I think it's you who referred to that in your document, why it is that the Council did not take more of a pro-active step, because you must have been getting these figures on a yearly basis as to who was registered in South Africa? And yet even when it comes to the question of separate facilities that many doctors practice in the country, it was only 1994 that a firm decision was made.

DR BECKER: The question regarding the training of medico-practitioners I think we have made the statement earlier that Council should have reacted at the time, which it did not. It subsequently also had the opportunity and I cannot answer the question as to why it did not because it was never brought up by members of Council, or the Council didn't receive any requests from outside bodies to address the matter. So that definitely did not take place and I think in retrospect it was a mistake on behalf of the Council not to have done that.

As far as the training of doctors was concerned it's a more difficult matter for us to assess because we had an analysis here today of the numbers of Black doctors being trained in South Africa. On our registers we've got no distinction between doctors. So everybody who is registered as a doctor and there is no way that we can give you accurate figures except by trying to tie the name to a face, but there's no classification in our register as to what race a doctor belongs to. So we don't have those figures which were given to us today.

DR RANDERA: Can I just follow up on that one. With respect of course Dr Becker maybe you are right that you didn't have that on your register but as I understand it many of your members were based in tertiary institutions, are you saying that no discussion took place at any time until recently on this issue?

DR BECKER: I have just consulted with Mr Prinsloo, we had no formal discussion at Council, ever, during my term when I was there until recently about this whole matter.

DR RANDERA: Dr Becker my last question is to do with something that Mr Prinsloo commented on in terms of amnesty. I understand the position that the Interim Council has taken but many submissions have named, will have named people who have been involved in human rights violations, health professionals, what would the attitude of the SAMDC or the Interim Medical and Dental Council be now if all that information was made available to the Medical Council in terms of future action that you may take?

DR BECKER: I think Mr Prinsloo explained earlier this afternoon what the procedure of Council would be. In other words those complaints would be handled firstly by the Committee of Preliminary Inquiry which would then decide either on having an inquiry or not. If an inquiry is advised, the Council is advised to hold an inquiry then a disciplinary committee which is the normal procedure for Council would be appointed, an inquiry would be held and that Committee would then decide on whether this person is guilty or not, as charged. And then also decide on a penalty.

Now Council has said quite unequivocally that it does not accept that a doctor can have amnesty, complete amnesty for any action between himself and his patient. He must always remain responsible for that. Although the mere fact that a person may have come here and have admitted to everything, and have in some words pleaded guilty to his actions, that that may be considered by the disciplinary committee as a mitigating factor in imposing a penalty. But surely that will make no difference whether he is found guilty or not guilty.

So the short answer is the Council will act in its normal manner with those complaints if it's received by Council.

DR RANDERA: Thank you Chairperson, I have no further questions.

DR WENDY ORR: Before I ask my fellow panellists if they have questions and I am sure they do, I am going to abuse the position of the Chair by asking a question myself. And that is that if, as according to the objects and aims of the Council, if one of your aims is to assist in the promotion of the health of the population of the Republic, and the promotion and maintenance of proper professional conduct, is it adequate that a body with these aims and objects sits and waits for complaints to come to it?

And swaddles itself in cotton wool or an ivory tower or I don't know how best to describe it and

adopt a kind-of a no news is good news policy rather than actually reaching out to that population, to that profession and ensuring that good standards are maintained?

DR BECKER: We've been discussing this unofficially amongst Council members of late and even previously, even during my term of office this was discussed and we have not found the solution to that situation. How do you handle this? Do you have Council members go around to hospitals and do inspections? Do you have Council members going to prisons and inspect and see what is happening there? Or do you appoint inspectors of the Council to go around and look at these areas? Of course the easy answer is that if you have the obvious ones, you read in a newspaper report or hear of things that Council may then react on those, and that I think Council can do.

But the other means a much more sophisticated Council activity which can be done. But one must also bear in mind that the Council is supported by the funds of the practitioners who are registered with the Council. It doesn't use any State funds. So there is a real danger that there will be objections from that side if this activity of Council is expanded to the extent where it involves all those inspections, etc. But that is a possibility.

DR WENDY ORR: Looking towards the future and future recommendations would it not be possible for Council to interact much more dynamically with those organisations which do exist, non-governmental organisations and other bodies in order for there to be an exchange of information which Council could then use to act upon, rather than waiting for specific complaints about individuals from individuals?

DR BECKER: I will ask Mr Prinsloo to respond to that.

MR PRINSLOO: Professor Karachiram, the President of Council asked me before she left to indicate to the Commission that this was in fact one of the issues specifically being addressed by the Interim Council. You will appreciate that the primary objective of the Interim Council was to advise the Minister and Parliament as to the process of transformation, and that has occupied the Council during the last 18 months. The Council has made a recommendation and legislation is now before Parliament to decide on the future structure and functions of the Council. And the time is perhaps now opportune for the Council to look outwards in terms of the transformation process. And therefore one of the recommendations is that in its composition there will be at least a 20% community representation on Council, and it is hoped that that will strengthen the role of the Council in being more in touch with the communities. But in

addition to that it will be discussed as a formal item as to how these functions of Council can be improved on a more pro-active basis.

DR WENDY ORR: Thank you. Are there any questions from other panellists? Glenda, Miss Wildschut.

MS WILDSCHUT: My question is related to the issue of autonomy. In your submission and recommendations with regard to the future you suggest that future Councils should maintain autonomy and act in a way that demonstrates that autonomy. Earlier in your submission you talked about the fact that the Council was influenced or operated within a particular milieu. Now given those two scenarios how is it possible then that future Councils can in fact practise their autonomy despite the milieu as it were, and act autonomously and act ethically even though the environment is not conducive to practising ethically?

MR PRINSLOO: Yes I think that is the crux of the matter and the major difference is probably the total different situation in South Africa in terms of the Constitution; in terms of the transparency required of bodies like the Council; and being held accountable. And although it will still operate in terms of an environment created by Parliament and by the social structures, those will probably be of such a nature that whatever decisions are taken by Council that it will be held accountable for that.

DR BECKER: If I may just come in on that. I think we notice the - someone referred earlier to the submissiveness of the population, we notice now that whereas previously Council decisions were accepted generally and there was silence about that by members of the profession, these days is being questioned, and I think that is now the safeguard which I think you are looking for in the future.

MS WILDSCHUT: Precisely. I was looking at how we can, in a sense, fortify individual practitioners and the collective itself that it would practice independently and ethically despite any milieu. We don't have the guarantee that in future we will have an environment which fosters or - I mean I hope that we will continue to, but there isn't that guarantee, whereas the profession can actually make steps and actually develop ways in which that guarantee can occur within the profession, and that's really what I was trying to question you about.

MS GOBODO-MADIKIZELA: Thank you Chairperson. Frances Ames, when she spoke earlier evoked the work of Hannah Ahrends and the theory of obedience to authority to explain the mentality of the time and for us to try and understand what was happening at the time. But you added another factor, another important factor which is the creation of a particular kind of culture, or as you called it a society that was

steeped in propaganda. And Solly Ratemane I think also added another factor which is fear.

Now looking at all these conditions, the ordinariness of human beings in the sense that anyone can commit atrocious acts or anyone can be part of these acts as Frances Ames said, and your proposal that the environment contributes to that, is it possible that in fact the dragging of feet as far as decisions in the legal case was concerned, was motivated purely by apartheid propaganda, apartheid ideology which is essentially racist, is it possible?

That the difficulty to reach a decision in respect of those doctors was really a result of the perception of Steve Biko as a Black person in apartheid society, is it possible that you were motivated by those kind of factors?

DR BECKER: Firstly if I think of the process that the Council has to go through in order to arrive at an inquiry I do not think the Council dragged its feet. What brought about this delay was the court case which came in-between on behalf of Drs Lang and Tucker.

The second part of the question of course is very difficult because I can't say what happened in people's minds when they took a vote on a certain matter, and whether they were influenced in other manners which we don't know about.

But my experience in Council has always been that people have been objective and have never thought of a patient or a doctor as either Black or White. I have never come across that, and I can say that with all sincerity. All the time that I've been on the Council, which is since 1980 cases were discussed. It was a case of Mrs so-and-so against Dr so-and-so, and there was never race as part of that thing.

MS GOBODO-MADIKIZELA: During the time you were in the Council what was the racial composition of your Council?

DR BECKER: I can't recall exactly, maybe Mr Prinsloo can.

MR PRINSLOO: Yes I don't have the exact numbers but it was overwhelmingly a White Council and a male Council.

MS GOBODO-MADIKIZELA: One other question. We heard this morning Sean, who was a medic in the army, he presented to us what seems to be a total violation of medical ethics at the macro level in the way in which they were allowed to handle patients in a hospital. And secondly, at a micro level he told us how when they needed psychiatric attention they were told by qualified psychiatrists that there was noth-

ing wrong with them. What would your position be if you established that in fact what Sean told us is true, as a professional body?

MR PRINSLOO: I think Dr Randera asked that question earlier. If evidence to that effect came to our notice then this would go the normal route of Council, inquiries, and the necessary steps would be taken against the practitioner if that was proved to be correct.

MS GOBODO-MADIKIZELA: Thank you Madam Chair. Towards the end of your presentation Mr Prinsloo you expressed a wish that you hope your presentation will promote trust between health bodies and the public, I mean just looking at the background which we have in our mind and hopefully the public, which has come from like specifically Leslie and Miss Ncanywa's presentation, Dr Leslie London, which addressed systematic abuse in particular, which aspects really of your presentation, which if people are listening out there would really begin to trust the health professionals, because that was your wish?

MR PRINSLOO: Yes, I think essentially it was a question that the Council, in its presentation, did not come here to defend the SAMDC. We tried objectively to state where the Council did things and also stated the things where the Council neglected to take action, and we hope that that at least would form the starting point or the basis of an openness on behalf of the Interim Council. And that is the other point of course, it is a transformed Council. It is no longer the SAMDC. In the light of the different aspects mentioned as to how the Council will function and on the basis of this statement of what it did and didn't do, we trust that that could form the basis of greater trust in the Council or its successors.

MS GOBODO-MADIKIZELA: Again just to assist you in this trust issue, what is it in the new structure which you think, if you had to sell it, people would really begin to trust? Because I am sure just to say - virtually everything is new in this country today, so what is it in the new name which in your own mind will counteract all what we have heard about systematic abuse and stuff like that?

MR PRINSLOO: Yes, the Interim Council and also the Council proposed, which is now the subject of legislation before Parliament, makes provision for a totally different composition of Council. As one example I have mentioned the question of community representatives. The input or the presence of those members on Council will no doubt ensure that decisions taken by the Council are also in the interest of the public, and that is of course the main objective of the Council is the interest of the public.

So I think it's a question of the structure of the Council, the composition and also, as was men-

tioned, the question of the framework within which the Council will function in terms of greater accountability.

DR BECKER: I think if I may add to that, one must realise that the medical profession and the allied professions is an all self-regulatory profession, that's why the Council is there, because the Council represents them and regulates their activities. And what the Council does and how the Council acts depends largely on their perceptions of what happens there. So if the medical profession is alert and the medical profession is active in guarding against abuses then the Council would know about it and the Council would be in a position to act against it.

MS GOBODO-MADIKIZELA: Thank you.

ADV POTGIETER: Dr Becker, an issue that was raised by Dr Randera in regard to the way in which the Biko matter had unfolded within the Council, you responded by saying that what happened was not really unusual, it is tantamount to what often happens in courts where a higher court differs from a view that was taken by a lower court. Is that really the only explanation for how this unfortunate matter had unfolded within the Council?

DR BECKER: As I said earlier, I said the Committee of Preliminary Inquiry had certain information at its disposal and they came to a certain conclusion. Subsequent to that the Council got itself involved in the legal requirements of rescinding a decision where new evidence was required which Council could not do. When eventually it came before the final Committee that Committee took its own decision on whether these people were guilty or not guilty, without being influenced by what happened at the other Committee. And that just drew the parallel, this is something which happens ...(intervention)

ADV POTGIETER: Yes but now - I am sorry. Are you finished? But now you see what you are really telling us is that we should conclude, as a Commission, that what happened was that these two decisions, the one not to act at all against these practitioners and the other one which eventually resulted in the most severe form of censure that can be imposed on a practitioner, now those two decisions is entirely attributable to an honest sort of process applied by two different bodies?

Bearing in mind that the suggestion that was made earlier that for example insofar as MASA was concerned, the Union was concerned, there was a suggestion of undue influence on the part of the Department of Health, taking into account the patent irregularity that occurred in this particular instance, can we

really reasonably conclude as a Commission that this was just an honest exercise of the minds of two different structures, honestly each coming to their own, although very opposing positions on the story? And that's my difficulty.

DR BECKER: I wasn't involved in the Biko affair from beginning to end, but I must just say that my experience of Council and particularly at the time when I was involved, that the Council's attitude was one of objectivity. I think I can say without fear of contradiction that there was no effort at cover-up by the Council of this matter. Everything that was done was reported on openly at Council meetings and it was reported in the Press as you know. Certainly no attempt was made to influence me during the second half of this episode, or any other member of Council which I know about. I cannot say that Government representatives on the Council did not express an opinion whilst this was being debated, but pressure on Council I must deny. I am not aware of that and I don't think it existed.

ADV POTGIETER: There has never been a suggestion of the Department of Health influencing unduly the process on the part of the Council?

DR BECKER: I have never even heard that mentioned by anybody.

ADV POTGIETER: You see to me it's perplexing to try and work out how, given the facts of this particular matter, and there's real consensus here that what happened was irregular, there's no question about that. And there were very clear views expressed about the way in which the Council dealt with this particular matter, very critical views towards the Council and I can understand that. I mean taking into account the facts of the matter.

And for one body, one Committee in the same body to come to a conclusion that there should be no steps at all, not even an inquiry, and the other one finding that there should be an inquiry and the inquiry resulting in what we know happened eventually. That's very hard to understand, for an outsider. That's why I am putting it to you. I know that you now represent the Interim Council, the new structure, but that we should put that difficulty to you because we are going to have to grapple with that ourselves.

DR BECKER: I understand your problem and I can just repeat what I said earlier, and that is that the Committee of Preliminary Inquiry had certain evidence at its disposal, they took a decision which eventually turned out to have been incorrect. There is no question about that. They took that decision on the evidence that they were presented with. Subsequently when an inquiry was held by the Council that

Council then had further evidence, verbal evidence given at the time of the Inquiry, they had the opportunity of cross-examining and listening to the evidence of Drs Lang and Tucker. So there is other evidence which was submitted subsequently to the Council. And as I have said if the Committee Preliminary Inquiry in the first instance had ordered an inquiry that evidence would most probably have come out at the time. But that is where our inquiry went wrong.

But I can repeat that I am not aware of any pressure being brought at the Council and that that influenced the decision.

ADV POTGIETER: I thank you for your assistance Doctor. Thank you Chairperson.

DR WENDY ORR: I think as the Truth and Reconciliation Commission looking back over the 34 years under review we have to be careful not to blame the Council for everything that went wrong. I do believe, however, that the Council had certain very specific responsibilities and duties towards the patients and the population of South Africa which perhaps it did not always observe, and I do hope that through this process of examining our past we can ensure that whatever grows out of the Interim Medical and Dental Council will be a far more pro-active and active body than the South African Medical and Dental Council of the past.

I want to thank you gentlemen for coming here today and for making the presentation. I trust that you will continue to be part of the process as we look at the transformation and the responsibilities of statutory and professional bodies who, after all, are the bodies we look to, to maintain the professional reputation and conduct of professions like the medical profession. Thank you.

DR BECKER: Thank you.

MR PRINSLOO: Thank you.

SUBMISSION BY THE SOUTH AFRICAN MEDICAL SERVICES

DR WENDY ORR: Our final presentation for this afternoon will be from the South African Medical Services and I ask Lt General Knobel and his team to please come to the table and Advocate Denzil Potgieter will be facilitating their evidence. Dr Ramashala reminds me that she and Adv Potgieter will be facilitating the evidence.

GEN KNOBEL: Madam Chair ...(intervention)

DR WENDY ORR: Oh I'd like to hand over to my two co-Commissioners who will swear you in and

facilitate your evidence.

GEN KNOBEL: I was just going to announce that all three of us will be contributing to this presentation. I will do the main presentation but when there are questions afterwards all three of us will participate. I was just going to suggest that all three of us could take the oath.

ADV POTGIETER: Thank you General and good afternoon. Brigadier can I perhaps ask you to just get back to the microphone before you take up your position, and could I ask you gentlemen please to rise for the oath and perhaps start on the left with - perhaps General you can give me your full names and then go down the line before I administer the oath.

GENERAL D T MASUKO: (sworn states)

GENERAL M KNOBEL: (sworn states)

BRIGADIER J L J VAN RENSBURG: (sworn states)

ADV POTGIETER: Thank you very much. You may be seated.

Dr Ramashala.

DR RAMASHALA: General is it my understanding that you are going to give a summary of your submission?

GEN KNOBEL: Madam Chair no, it will certainly cover some of the aspects in our written submission, but it will also have some added information.

DR RAMASHALA: Okay. Would you proceed then.

GEN KNOBEL: Thank you Madam Chairlady. May I also say on behalf of the Medical Service that we appreciate the opportunity to be able to take part in the process of truth and reconciliation and to be allowed to make a presentation also at this meeting today.

Before starting on the presentation I would just like to make the following remark and it pertains to some of the other presentations that you have already listened to. The Medical Service has undergone a process of transformation which really started in 1979, and it will come out in my presentation why I refer to this specifically.

In the period under discussion we have had four Surgeons General. The original Surgeon General that was in the office from 1960 to 1969 was a General Raymond who is still alive but not in very good health at the moment. His successor was General Cockroft who was the Surgeon General from 1970 to

1978. He died some years ago. His successor was my predecessor, General Niewoudt, he was the Surgeon General from 1978 until 1988. I took over as Surgeon General in March 1988 and I will be retiring in December this year when General Masuko on my right, who is the Surgeon General designate, will take over the office of Surgeon General.

Now why I refer to the process of transformation is that it actually deals with the period in which General Niewoudt became Surgeon General in 1978 and was continued by myself from 1988.

It is also important to note that all the Surgeons General that I have mentioned were all members of the Medical Council, not in terms of the office that they occupied, but as appointees of the Minister of Health, and likewise I also served on the Medical Council from 1988 onwards. And you will see how our functioning intertwines closely with the functions of the Medical Council. Hopefully when the new Act is promulgated that Mr Prinsloo referred to, the new Surgeon General will be a member of the Council in an ex officio capacity.

I would like to call my presentation, **"The South African Medical Service as a Unique Health Provider"**. Internationally it is a standard principle that members of defence forces who risk physical exposure, injuries, disablement or death in the service of their country can depend on a dedicated health service that is professional, comprehensive, self-supporting and available anywhere and at all times.

This international norm places a moral obligation on a country to make provision in its Department of Defence, for a Surgeon General, and a unique uniformed health service that can render military health support as its primary function. This military health capability must be trained and fully incorporated into the doctrine and standing operational procedures of combatant forces.

This implies military command and control, communications and logistics within the health capability that is unique in its own right and is markedly different from that of civilian health capabilities.

Furthermore, this capability must be retained between conflicts since if this is not done, it will be impossible to provide the necessary health support to armed forces when required. At the same time it is then available to the State in national health objectives and during other man-made or natural disasters.

The whole concept of a military health service is further aimed at the fact that no medical fund can or will be able to cover the casualties that might occur in an armed conflict, neither will it be able to act with the same discipline, efficiency, cost of activity and mobility required in a combat situation or during

natural disasters.

The South African Medical Service, through its diversity of health professions and infrastructure developed to render a comprehensive health service in support of forces in the field has a far broader capability than any medical aid scheme and this implies that although the organisation may be placed on a comparable hierarchial level the organisation cannot be compared directly with any medical aid scheme.

This above introduction can be summarised as follows. It is a unique strategic capability which is there firstly to ensure a healthy security environment, and secondly, to ensure a secure health environment.

The history of the Medical Service can be traced back to 1913 with the founding of the South African Medical Corp of the South African Army. In the same year provision was made for the employment of volunteer nurses which system fell away in 1921 with the establishment of the South African Military Nursing Corp. This created a second military health service. Each had their own executive.

The following year 1922 saw the creation of yet another military health service in the South African Air Force. There were then three services and this endured until 1960 when the South African Navy also established a Medical Corp. Now clearly we were on our way to having four different medical services within the Military.

1970 saw the first rationalisation with the amalgamation of the South African Medical Corp of the army and the South African Military Nursing Corp as the South African Medical Corp under one Surgeon General. The other two arms of service remained, or the corps of service remained with their own medical services.

During 1979, and this is the period that I was referring to earlier on, the South African Medical Service came into existence under General Niewoudt fusing together the three military health services into a separate, independent arm of service of the National Defence Force, the so-called “fourth arm” of service.

Now over the years of this transformation process the mandate of the Medical Service became clear and this is as it stands today. It is derived from the following sources. First of all the Constitution of the Republic of South Africa; secondly, the Defence Act; thirdly, supplementary legislation of which you can see the examples on the screen there, all of which impacts on all the statutory professions that are

embodied in the South African Medical Service. Finally, also from the defence strategy of the Department of Defence, which in itself is derived from the Defence Review and the White Paper on Defence which is currently much in the news.

The mission of the South African Medical Service is to provide and to ensure as part of the South African Government's Southern African strategy a military health service that is complete, comprehensive, self-supporting and available at all relevant times and places within the boundaries of our country and even outside if required, all of which to ensure the physical, the psychological and the social well-being of the entire military community, as well as other approved clients.

This mission is accomplished by a management philosophy which is based on the following principles. Efficiency, cost-effectiveness, participative management, standards in keeping with international norms, professionalism, ethics in keeping with internationally accepted declarations and practice, future orientated and innovative, client-orientated, with equal opportunities with merit as basis, non-discriminatory in respect of race, gender, religion, culture and creed, enabling human resources development, and finally with an affirmative action programme towards a more equitable system.

The guiding values within this management philosophy are, the fostering of all religions and religious tolerance; improvement of self-image and the promotion of a healthy and stable family life; better understanding of others and respect for values entrenched in the Bill of Rights and the National Defence Force Code of Conduct; a healthy social life; improvement of the quality of the working environment; promotion of nobleness of the professions; promotion of discipline and the maintenance of physical and mental well-being.

Within that framework the functions of the Military Medical Service of the SAMS are the following - Primarily medical support to the South African National Defence Force and previous to the National Defence Force to the South African Defence Force. Further, Military Medical cooperation and assistance as and when required and as instructed by the Government. Thirdly, Medical support to the South African Police Service and the Department of Correctional Service. Fourthly, in the preservation of life, health and property. Furthermore diplomatic assistance operations, disaster relief operations. Support to other State departments resulting from the unique capabilities that are found in the Medical Service. Support to any State department in socio-economic upliftment programmes. Finally, provision and main-

tenance of essential health services.

A word about the clients. Primarily, clearly the South African National Defence Force and all their dependents. But in the State dispensation, Central government, other governmental departments, all the provincial authorities and the local authorities. Thirdly, secondary to the above primary clients any private sector patient as approved by Treasury and according to the regulations of the Auditor General.

The technologies used to maintain or to attain the mission are medical expertise covering the entire spectrum of health disciplines particularly in the fields of evaluative, preventative, promotive, diagnostic, curative and rehabilitation services.

I am not going to say much about the structure of the service, but just to sum it up, all these capabilities are deployed in the Medical Service in static medical force structures, in mobile medical force structures and in specialist medical units.

The origin of an independent arm of service in 1979 was of great importance because it provided the Medical Service with an autonomy which had the following characteristics. I am sure this will be the subject for discussion later on. In the first place it had to have an identity, with its own uniform and clearly recognisable within its deployments. Secondly, the SAMS has an image of being a reliable source of medical proficiency in times of need.

Thirdly, it has to be able to perform independently, to perform delegated tasks. And also in such a way that it is independent by means of its various staff systems.

Furthermore it has to be professional, high standard and professional and proficiency is well documented. It must have its own command and control system with the Surgeon General as its commander. It must be self-supporting, because of the unique capabilities that are in the Medical Service of the Defence Force, it is important that it should be fully self-supporting.

It must have mobility. The medical rapid deployment force has great mobility and is air, sea and land transportable and capable of maintaining all functions rendered within a static medical infrastructure.

It must have clear and efficient line of communication and a high degree of participative management.

All analyses show that the Medical Service is cost-effective and it's capable of supporting its primary and secondary tasks.

The numerous occasions on which the units or directorates of the Medical Service have received high accolades from the National Productivity Institute reflect the level of productivity that is maintained.

It must be ready to be deployed at any time at short notice.

It must show that it is, as an independent arm of Service, impartial to all parties concerned and it is there to serve those who are in need, as indeed stated in its motto, "We Support the Brave".

The existence of the Medical Service as a single independent health service for the National Defence Force results in a single medical standard for all arms of service.

The existence of the Medical Service as an independent dedicated centralised health service leads to a unity of effort.

Finally joint planning between the arms of Service is facilitated by an independent arm of Service.

It is clear from the above that where the Medical Service has a primary operational responsibility to the National Defence Force and also the other security services in the Republic of South Africa, it does, at the same time, commit itself to making available its collateral capabilities to the State and to the population at large as a secondary responsibility.

I want to talk about these two major responsibilities briefly. It is the doctrine of the golden hour that determines that a combatant who is wounded or injured immediately becomes the responsibility of the South African Medical Service. This principle equally to members of own forces and to members of enemy forces.

It entails that the patient be cared for by a medical orderly within 20 minutes and by a medical officer within 40 minutes of injury. Immediate medical care in terms of resuscitation, stabilisation and preparation for evacuation of patients from the battlefield or on board ship is necessary. This also implies medical officers and medical orderlies trained to be air dropped with special forces and with paratroopers.

Evacuation takes place to a military medical mobile or static structure where life-saving surgery can be performed and/or patients treated. This is followed by transportation to military hospitals where combatants will get the necessary comprehensive health care and where necessary patients will be moved to a rehabilitation centre.

To achieve this it is necessary to have specialised services like maritime medical services, aviation medical services, trauma, psychology and psycho-strategy services in place and measures for the detec-

tion of radiation and chemical and biological warfare agents and the treatment of injuries caused by such agents, as well as the ability to acquire and to stockpile and to distribute medical supplies and to have a medical management information system which supports this entire service.

The Medical Service is unique in the Republic of South Africa and even internationally since it encompasses the whole spectrum of professional health services within the above multi-disciplinary operation.

With regards to its secondary function. During peace time the secondary functions of the South African Medical Service becomes more prominent than the primary function. Through the creation of this unique military operational health support system the SAMS has become a national asset with unique capabilities and a large collateral utility capability which can be utilised to the best possible advantage in promoting national, non-military health interests.

It possesses the inherent organisation, the skills, the mobility, the equipment, the discipline and the working procedures to perform a number of health-related tasks more efficiently and on shorter notice than any other comparable State or private organisation.

To maximise return on investment within the SAMS by the State its unique capabilities in collateral utility are used by the following means.

Firstly, acting as a medical rapid deployment force for the State in disastrous situations. Examples of these are the Oceanos disaster, the Merryspruit sludge dam disaster, the Delmas typhoid epidemic and the nurses strike that occurred a number of years ago.

Secondly, acting as an agent of the State in respect of its unique capabilities in the fields of aviation medicine, maritime medicine and chemical, biological and radiation defence.

It uses its unique capabilities and collateral utility to the best interest and advantage of national non-military health interest. This, inter alia, implies support to the departments of Health, Foreign Affairs, Transport, the Police Service and Correctional Service.

Support to these departments consist of the following:

Firstly, the responsibility of health care to the President, the Deputy President, Cabinet Ministers and Members of Parliament;

Secondly, immunisation campaigns; rendering of essential services during labour unrest and strikes;

disaster relief operations; the training of primary health care personnel for the health authorities of the country; medical examinations of dignitaries, flight crew, divers and personnel on duty in South African Research bases in the Arctic Circle. Treatment of Police Service and Correctional Service personnel and animals. Social upliftment programmes through certain RDP project. Provision of medical supplies and specialist advice and services in the unique capabilities within the service.

By virtue of its organisation it is the only medical rapid deployment force for disaster relief at large or national scale which is available to the State.

An amplifying factor is that of the spectrum of professional health functions in the SAMS; the highly integrated multi-disciplinary team concept and single command.

In essence it utilises the faith and the capital investment provided by the taxpayer, not only for military gain, but to ensure health services for the nation in times of need.

I need to say something about the reconstruction and development programme. Within the RDP policy framework it is stated that one of the first priorities is to draw all the different role players and services into the national health system. This must include both public and private providers of goods and service and must be organised at national, provincial and community levels.

The RDP further states that all policy decisions affecting health must take into consideration the fact that South Africa is an integral part of the Southern Africa region and has regional responsibilities to prevent and contain the spread of disease. Since its introduction the Medical Service has become involved in no less than 27 areas of reconstruction and development in the RSA as is shown on that transparency.

In particular I would like to refer to three unique projects which were already functioning in the SAMS before the RDP was announced.

First of all Project Harmonia. The influence of music and song on individuals and groups is no secret and can be traced back to very early days. There are numerous examples of how music and song were used during religious ceremonies, battles, community activities and prestige occasions ...(intervention)

DR WENDY ORR: Order please.

GEN KNOBEL: .... with the aim of creating the correct atmosphere when shaping characters of men and

women.

Madam Chair if the audience would like us to show we can have a sing-song after this meeting.

In 1989 it was decided to embark on annual community singing project in the Medical Service of the Defence Force. The Project was registered as a nation-building Project with the primary aim of creating harmony in body, soul and spirit amongst all the members of the South African Medical Service through the harmony created by music and song.

Project Harmonia would further create opportunities for both individuals and groups to cultivate feelings of patriotism, pride, devotion, positivity and assert confidence, encourage self-discipline, integrity and selflessness, provide opportunities for enjoyment and relaxation; improve self-image and productivity; encourage inspiration and motivation and ensure loyalty and support and involvement; enhance feelings of camaraderie, cohesion and cooperation and overcome uncertainty, fear and discouragement.

Madam Chair, if you consider that in the Defence Force we have no less than 125 religious denominations, we have all languages, all cultures, all population groups and both males and females, then this Project has a very major role to play in creating cohesion. Over the last nine years it has made very definite contribution to cohesion and spirit within the National Defence Force.

DR WENDY ORR: General Knobel I am sorry to interrupt you but we are very pressed for time, so could I please ask you to sum up within the next few minutes so that we can move into questions, because we do have many of those.

GEN KNOBEL: Madam Chair I am very upset to hear this because the next two projects impact on some of the presentation that we had this morning. I will try and do it as quickly as I can, but I would like to mention them.

Project Curamus, a number of shortcomings and deficiencies in the management of disabled persons in the South African Defence Force led to the launch of Project Curamus in April 1990. The object of this Project was prevention of disability, treatment and stabilisation; rehabilitation; retraining and employment; continuing care and material compensation; equal opportunities, spiritual care and so on. I am not going to mention them all.

Participation by the disabled and acceptance of their own responsibility were attained by funding or founding a Curamus Association. All office bearers are themselves rehabilitated persons. The Asso-

ciation aims to allow serving and former serving disabled members of the National Defence Force, Police Service and Department of Correctional Service to achieve the highest possible level of independence.

May I just sum up then as you asked me. It deals with physically, psychologically and socially disabled members of the Defence Force.

I am sorry that Sean this morning had to say that he was turned away from the Defence Force. He should have been included in this programme of Curamus and then we would have been able to deal with his post-traumatic stress. We are dealing with a number of them at the moment.

I am not going to say more about that, but just the following.

At the moment the Medical Service is involved in the National Integrated Stability Strategy on an on-going basis and we are awaiting new legislation which will enable us to include all the ex-MK and ex-APLA members also in the programme. In this regard General Masuko has already embarked on a programme of identifying and tracing those members of APLA and MK.

The last one, Project Fairway, just very briefly, was initiated in 1992. The aim of this project was to train primary health care and secondary and emergency health care orderlies within the National Defence Force, not only for the needs of the Medical Service itself, but also to make provision in the human resources needs of all the other health authorities in the country. Over the last five years 1,200 of these orderlies have been trained and have also registered with the statutory council.

During 1996 Treasury approval was obtained to expand the programme to include the training of registered nurses of the Department of Health and Provincial Health authorities with the support of sponsors from the private sector and it's envisaged that we will train 700 nurses to fill the gap in the primary health care management needs of our provincial authorities.

I will conclude Madam Chair. Having briefly discussed the mandate, mission, role and functions of this comprehensive service and having indicated that it has great potential in making a major contribution to reconstruction and development in our country I would like to conclude by saying, that as Surgeon General it has been my great privilege and honour to be in command of this organisation since 1988.

It is an organisation of which I am justifiably proud with human resources that are second to none in this country. Of the 85 occupational groupings in the National Defence Force 52 are found in the Medical Service, of which 27 are statutory professions regulated by the respective statutory councils.

This represents over the last nine years, since I became Surgeon General, a total of 15,000 professional members who served in the organisation in a permanent or part-time capacity.

With regard to this Service I want to state quite categorically that I have never had any reason to doubt the professional conduct and ethical norms and standards of the organisation as a whole. Certainly I accept responsibility and accountability for any action of any professional member of the South African Medical Service who acted within the mandate and mission of the Service as I have shown you, or as directed by myself through the command and control structures of the organisation. In this statement I also have the full support of all the members of my Command Council.

If, however, there is evidence and we have listened to some of the testimonies today, that any professional member of this organisation has acted outside the directives according to the mandate, role and functions I've discussed or acted in an unethical or unprofessional manner, according to the guidelines of the various statutory councils with whom they are registered, then I would like to say the following:

I would firstly like to apologise on behalf of the organisation to any member of the South African community that may have been adversely affected by such actions.

But in the second place I would like to confirm that I and my Command Council will take whatever steps deemed necessary to investigate and to bring to justice such activities. Clearly in this we will have to also depend on the support of the statutory bodies. The statement by the Medical Council in this regard is of great importance.

In this declaration I also enjoy the full support of Major General Masuko, next to me here, as the Surgeon General designate, who will take over command as I indicated in December this year.

I had a discussion with General Raymond, the retired previous Surgeon General who occupied the position on the 1st of February 1960 to the 31st of March 1969, and as I said to you he is in ill-health at the moment, he is the only remaining living former Surgeon General of the SANDF, and he confirmed that he would be more than willing to make a similar statement with regard to his term of office, to the TRC if so required.

Finally, what of the future? The SAMS is currently involved in transformation to create an affordable, appropriate, accountable and adequate National Defence Force Medical Service which is totally

representative, transparent, legitimate and professional. It is striving to become fully representative of all populations, traditions, cultures, languages, cultures and religions found in the RSA.

In terms of gender representivity it currently consists of 52% females and 48% male members.

It remains fully committed in providing health support and to contribute to the process of the Truth and Reconciliation Commission, and I want to quote, like some of my colleagues have earlier today, from the words of Abraham Lincoln. With the following spirit the words in his second inaugural address in 1865, I quote,

> "With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the Nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, and to do all which may achieve and cherish the just and lasting peace among ourselves and with all nations".

Thank you.

DR RAMASHALA: Thank you General. I hope you have sense of humour because I'm tempted to say, where do I sign up?

GEN KNOBEL: Well Madam Chair we can arrange that for you on Monday.

DR RAMASHALA: Sir, on the basis of your larger submission and on this submission I'd like to make some comment which will be the basis for our questions to you.

First Sir, we have to face our past, and this submission has to address the past, in particular the past abuses. The omission at the centre of this submission is the complete silence around the war in which the SADF was involved. We are told by you, and through your submission, of policies, structures, achievements and the war is mentioned almost tangentially now and then.

Apart from the absolute devastating impact of that war on both civilian population of Southern Africa, as well as the SADF's own forces themselves, these structural issues of reorganisation and expansion that you've just described that are so articulately referred to, are completely connected to and dependent on the escalating war situation.

The great strides made in SAMS, medical expertise is underpinned precisely by its concrete involvement in the war situation. In somewhat the same kind of way in which the great strides in medical

science made in the 19th century are so intimately connected to colonialism. Whereas these strides are presented as some great academic and scientific medical achievement. You are silent on the war. And so I need to lay the basis for our questions.

The first question Sir is, were you and SAMS involved in a war during the period of the mandate of the TRC? Now when I say you, I mean the "royal you". Sir, you were part of the SANDF and the SANDF was at war in the Southern Region, SADF.

GEN KNOBEL: May I please start answering your question because I'm going to get ...(intervention)

DR RAMASHALA: The first question I am asking Sir is would you agree that you were in a war situation?

GEN KNOBEL: Yes I would like to qualify the answer. Certainly we were involved in the war that the SADF was conducting and I accepted that the submission that had been made to you by the SADF, by John Meiring and Charl Mortimer would have been read along with our submission. Clearly the Medical Service was totally involved and totally along that time.

But at the same time we would like to point out to you Madam Chair, that at the present time in this country there are more companies deployed within the boundaries of South Africa of the National Defence Force than that were ever deployed in Angola, and I am still totally involved in this war to try and maintain peace and security and to support the Police Service in maintaining law and order.

DR RAMASHALA: Sir, I would like to repeat what the Archbishop said this morning.

> "A nation that does not face the truth about its past is likely to repeat it".

Now, in the context of your admission that you were in a war situation I'd like to pose the following.

In Chapter 1 of your submission under the title "History of the South African Medical Service, SAMS, 1913-1997", the following statements are made, and I quote:

> "57. During 1975 and 1976 SAMS provided extensive service to the troops involved in the Angolese Civil War".

And in no.64, and I quote;

> "64. SAMS gave medical support in South West Africa during the successful series of attacks on SWAPO bases in Angola during 1978 to 1983. These operations included Reindeer, May 1978; Septic, June 1980; Protea, August- September 1981; Daisy, October and No-

vember 1981, Supa, March 1982 and Askari, December 1983".

In the light of these descriptions of SAMS' involvement in the war situation, one, do you have any statistical evidence, data or other information regarding the war and its impact on medical services or other developments?

The second question coming from this, do you feel, as you have not provided any statistics so far, do you feel that the submission of the SAMS to the TRC can accurately represent the role of the SAMS without providing such information?

Quite frankly Sir, I would have expected some kind of sets from a statistical perspective of the medical impact of this war. Would you please address those two questions that I presented to you.

GEN KNOBEL: Certainly Madam Chair. I would like to point out the following. When we made our submission the submission was handed in by hand to Dr Wendy Orr. We were given the indication that we would be given questions that the TRC wanted answered before the 6th of June. We did receive two questions which we dealt with this morning in a separate communication with the TRC with a smaller committee. We had not received any questions from the TRC until lunch time today when the list of questions that you now have in front of your are being dealt with. In all fairness Madam Chair I would like to say to you that if you give us the necessary time we will provide you with whatever statistical evidence we can give you.

At the same time I want to make it clear that in a situation where you deploy a very large part of your organisation in support of the Army, the Air Force and the Navy in a day-to-day basis in terms of day-to-day running of their medical requirements but also supporting them in operations, it is extremely difficult to give you an account of what had occurred over a very long period of time. But I will certainly go back and unearth these statistics and will give you the answers that I can give you.

When you asked me whether this can accurately represent the role of the SAMS I agree with you, I would very much like to give you a far more complete picture of what the SAMS did. You heard this morning what was given in evidence here by Sean. I was quite proud of what he told you here because it showed you exactly what the role was that the Medical Service had to play and under what extremely difficult conditions our medical orderlies, of which he was one, had to try and provide a professional service, not only to our own troops but also to troops that were over from the enemy side and the local

population. And the hospital in which he worked we also looked after the local population in Oshakati.

But the answer to your question is, certainly we will try and give you whatever information you require. But I do think it would be fair to give us more time to give you this information.

DR RAMASHALA: Sir, may I say that as you prepare answers to these questions bear in mind that my question is in the context that SAMS is operating within the concept of caring, because that is what medical care is about. And therefore as you prepare the statistics I'd like you to address a variety of issues that will come out of these questions that relate to the issue of caring. Thank you.

GEN KNOBEL: Madam Chair you have my undertaking that every question that you have posed here will be answered fully and truthfully and as completely as possible, exactly in the context that you have put it to me.

ADV POTGIETER: General, just in an attempt to fill in that gap around the war, have you taken note of the questions around your - the questions concerning statistics concerning your involvement in Angola and Namibia?

GEN KNOBEL: Yes I have.

ADV POTGIETER: You've got all those questions?

GEN KNOBEL: I've got these questions in front of me that were given to me at lunch time.

ADV POTGIETER: Okay. So you will attempt to furnish us with those statistics as well?

GEN KNOBEL: That's exactly what I have undertaken to do and I said I would do so as completely and as honestly as what I can possibly do. And I will also tell you if I do not have the statistics available.

ADV POTGIETER: That's fine. We will see if we can help you. Now what about the question concerning the role of SAMS in ensuring that the SADF complied with the Geneva Convention, can you shed any light on that, the questions and the sub-questions in regard to that?

GEN KNOBEL: Yes. All the instructions that were given by myself, and certainly as far as I am aware by my predecessors, were totally in line with what the Geneva Convention provided. Any member of the Medical Service who acted outside those instructions have done so either on their own initiative or under the influence of the military components which they were supporting.

ADV POTGIETER: But did you in fact, did SAMS visit prisoners of war, specifically?

GEN KNOBEL: Yes, we also treated prisoners of war.

ADV POTGIETER: And were you aware of instances where prisoners of war were turned to join the SADF or allied forces?

GEN KNOBEL: Exactly what do you mean by "turned", what do you mean by "turned"?

ADV POTGIETER: Well we've listened to Sean this morning.

GEN KNOBEL: I know I have also listened to Sean, I would like to know exactly what is meant by "turned". Are you talking about hearts and minds?

ADV POTGIETER: Exactly captured - no, no, no, no, apart from that, captured enemy that were turned into supporting the Defence Force, SA Defence Force, did you take note of that kind of instance?

GEN KNOBEL: Yes I did.

ADV POTGIETER: And how that happened. How these people were persuaded.

GEN KNOBEL: How they were persuaded?

ADV POTGIETER: To join you as their enemy.

GEN KNOBEL: Advocate Potgieter I assure you, as far as the Medical Service is concerned they had only one concern and that was to provide medical support to every person who came under its care. It was not involved in any activities that was part of the rest of the Defence Force that may have been the type of things that you and Sean have described. Never at any time was any member of the Medical Service involved in such activities.

If you, however, have evidence to that effect, now I'm talking about evidence, I would very much like to have that and I will have it investigated and I will refer it to the necessary statutory councils to deal with it in the way that they should deal with such activities of professionals.

ADV POTGIETER: So we should understand that you haven't taken note of any of these kind of instances and any irregularity that went with that? You are not aware of any irregularities?

GEN KNOBEL: I am not aware of any Medical Service member transgressing, in any way, what you describe as the Geneva Conventions or the stipulations and the ethical norms and standards of the particular councils to which these members are members or registered with.

ADV POTGIETER: Can I refer to the next question which has been formulated for you, and that is asking you to explain what the indirect effects of the war were with respect to issues such as nutrition etc. Are you able to shed any light on that or do you need some time to consider that?

GEN KNOBEL: I would certainly need some time to consider that. Are you referring to Angola or to Namibia or?

ADV POTGIETER: To both of them.

GEN KNOBEL: Yes I think we will be able to give you some answer to that.

ADV POTGIETER: Thank you.

DR RAMASHALA: I think for the record General let me put the questions, read the questions so that they go on the record. This refers to Advocate Potgieter's question on the issue of Namibia and Angola. First question ...(intervention)

DR WENDY ORR: If I may just interrupt. What Dr Ramashala is going to do is read the questions out to go on the record and we will then ask you to take your time to respond to those in writing, make a supplementary submission. We don't expect you to answer those questions now.

DR RAMASHALA: Okay. The first question.

1. Can you provide us with information regarding the approximate number of Namibian civilians who received medical treatment from the SAMS?
2. Can you provide us with the number of PLAN, MPLA etc soldiers who received medical treatment?
3. Can you provide the Commission with the number of Unita Angolans who received medical treatment?
4. How many POWs did SAMS treat?
5. What was SAMS role in ensuring that the SADF complied with the Geneva Convention?
   For example did SAMS visit POWs?
   Were there instances where the Geneva Convention was not adhered to?
   Where detainees were "turned" was SAMS aware of these occurrences?
   If so what was the response of SAMS in such cases?
6. Can you explain what the indirect effects of this war with these countries were? With respect to the issue of nutrition that Advocate Potgieter just referred to.

The next section deals with the effect on and within the SADF.

1. Could you provide us with information and statistics regarding the effects of this war

within SADF itself?

For example, how many SADF members were killed, injured, disabled in combat and other circumstances, post-traumatic stress disorder?

How many SADF members were treated in the operational area for psychological reasons relating to PTSD? Were cases and reports of such cases followed up? If so, in what manner?

How many discharges were given or granted on the basis of PTSD?

What methods of treatment were used in these cases?

For example, was shock treatment ever used? If so what criteria were used before such method of treatment was undertaken?

Do you have information as to whether there was difference in the number of instances of PTSD in national servicemen versus permanent force soldiers?

The next section is on Medics.

1. Did Medics, under any circumstances, carry firearms?

You know there have already been allegations about that, so you need to deal with that too.

2. What disciplinary structures and procedures were operative within SAMS?

How many disciplinary hearings involving Medics in the operational area were held?

And what was the nature of the offences at issue?

There is considerable dispute around the veracity, for example, of place, date and reason given with regard to the issues surrounding deaths and death certificates. Questions.

1. What was the role of SAMS Medical Officers in this regard?
2. Can you tell us whether the SAMS have undertaken any investigation of this issue?
3. Were Medics ever instructed to give false particulars?
4. Were Medics ever found to be engaging in such activities, i.e. the falsification of information?
5. Were there any circumstances in which such activity was deemed necessary, i.e. the falsification?
6. What disciplinary structures and procedures were in place to deal with such violations?

The next area of enquiry is involvement in broader SADF policy and command structures connected to war.

1. Can you tell us what command structures you participated in or were a party to where general policy on war would have been formulated?
2. SAMS had an Intelligence component, MS2, I believe, what were its functions? What role did it play in the war situation?
3. How did it relate to other SADF Intelligence functions and components?
4. What role did SAMS play in relation to psychological warfare, the WHAM, Winning Hearts and Minds campaigns for example?
5. To what extent was SAMS involved in formulating such policies?

The next area of enquiry, development in South Africa.

1. Was SAMS involved in the national welfare or the National Security Management Systems?
2. Did any member of SAMS sit on any local JMC structures?
3. What was SAMS experience of the deployment of SADF troops in the townships, particularly in the mid-1980's?
4. Did these troops experience PTSD as a result?
5. Did any patterns emerge from this with respect to region, type of experiences and other observances?

The next area of enquiry is homosexuality.

1. What was the SADF's policy with respect to sexual orientations, specifically homosexuality?
2. Did SAMS play any role in the deployment or implementation of this policy, that is, did it contest or support this policy?
3. Was SAMS Director of Psychology involved in treating homosexuals?
4. What methods were used, for example, was aversion therapy used, etc?

The next area of enquiry is conscription. What kinds of research did you do, or what information do you have with regard to,

1. What was the psychological impact of conscription?
2. What stresses emerged out of that?
3. Did these stresses increase as conscription or the war intensified?
4. Did conscription in South Africa experience the same level of disorders as conscripts in Namibia, or were there any differences?
5. What consideration has been given to the psychological needs of ex-conscripts?
6. Has any assistance been suggested or provided to the ex-conscripts?
7. Can you tell us what the rate of suicide was among conscripts? Sean's evidence this morning suggested that there must have been at least 10 national servicemen suicides in Ondangwa due to the conditions during the period Christmas and New Year 1982 and 1983. Did you collect any statistics from that? And what was the follow-up?
8. How did this compare, that is the suicide among conscripts, how did that compare to the suicide in the general population?

The next area of enquiry, de-briefing and interrogating prisoners, including psychological torture. There is evidence that such practices occurred.

1. How and to what extent was the Directorate Psychology, and the psychologists working in the structure of the DP involved in these practices?
2. Was the DP involved in "turning", MK, APLA members into SADF operatives?
3. Were they involved in getting information out of prisoners?
4. Were either of these objectives accomplished by influencing them psychologically in a direct manner using emotional blackmail, sensory deprivation or other techniques intended to break human being psychology or human spirit?
5. Was the DP involved in advising other SADF members responsible for de-briefing or torturing of prisoners and/or "turning" freedom fighters in the psychological techniques used to accomplish these objectives?
6. Were psychologists present during interrogation and torture?
7. Did they interfere when they were convinced that the methods used were unethical?
8. How, and to what extent was DP involved in preparing soldiers for the front, "and main-

taining their morale", for example by increasing their hate for the enemy, by de-humanising the enemy, that is the belittling action of killing kaffirs, or by inciting them to prove themselves either by killing the enemy or through other means?

9. What was the pro-active role of DP in preparing and maintaining the morale of troops deployed in the townships?
10. How was the DP involved in the propaganda machinery and the diffusion of mis-information?
11. Did the DP serve in the capacity of consultant to other SADF or government structures regarding the intimidation and the demoralisation of the Black population?

Some psychologists were working in other structures of the SADF such as Intelligence and Communication.

1. What was the difference between your psychological role, that is DP of SAMS and theirs, that is those that worked in Intelligence and Communication?
2. How did you collaborate with them?
3. If you were not involved in their type of work what did you do when you were under the impression that they were being unprofessional in their work?
4. What is the role of DP in the training of special forces?
5. Could you outline the psychological profile required for selection to the special forces?
   I refer you here to page 14 to page 22 -IV, no.14A in your original submission.
   Has this undergone any developments in recent years, or improvements in recent years?
   You have not alluded to that in your submission this afternoon.

We are interested in SAMS' involvement in the production of scientific knowledge and experimentation, e.g. you list as one of your activities, research, and we'd like to know a little more, in particular page 22-IV, no.14B, Project Bokviet.

In this regard,

1. Could you tell us what SAMS role was?
2. Did SAMS undertake scientific research which was directly informed by the state of war of its activities?

And here I refer you to page 22 -IV no.13E, no.13C.

1. Were human beings involved in any such research experiments?

   For example, were psychological experiments done involving troops and/or captives?

2. What was the role of nurses in SAMS?

3. Can you elaborate on the extent to which nurses experienced discrimination within SAMS?

4. What steps, if any, were taken to address this issue?

I will ask my colleague if he has anymore questions with regard to that.

May I also suggest that there was another project which was done with a university, and I shall not specify, but I shall specify in private with you,

1. When was the project started?

2. What were the objectives?

3. And when was the project discontinued?

Thank you.

DR WENDY ORR: I realise that it's impossible for you to answer all these questions now, and I apologise that the questions weren't sent to you sooner, but Dr Ramashala who was given the very difficult task of composing questions around your submission has been away in Geneva and only returned recently.

I do want to express concern, however, that an organisation which has gone through the process from November last year with the Truth and Reconciliation Commission and all the other organisations which agreed to participate, a process which is meant to look at human rights abuses which occurred in the field of medicine at the perpetration of collusion with prevention of and resistance to, presents us with a submission which does not once mention the term human rights. I find that worrying.

I also find it deeply distressful that you can listen to the testimony of a young man like Sean, who has been through the most horrendous experiences, for which he was not adequately prepared and from which he was not adequately debriefed, and his experience is not unique, I have spoken to a number of conscripts who were given no debriefing, I am deeply concerned that you can listen to someone like him and say you feel proud. I listen to someone like him and feel horrified and ashamed.

I trust that you will give due attention to the questions that Advocate Potgieter and Dr Ramashala have posed and that we will have an opportunity to speak again about your further responses.

I want to say thank you to those of you who have stayed here this long. I want to say thank you to you gentlemen for coming from Pretoria. I trust that you will be staying for tomorrow's proceedings, particularly for the session which looks at the way forward.

I would now like to ask Glenda Wildschut to close off for us.

GEN KNOBEL: Dr Orr excuse me.

DR WENDY ORR: Yes.

GEN KNOBEL: You made a remark which I really feel I should respond to, because you certainly did not understand what I said when I said I was proud. I am proud of every Medic who worked in the Medical Service and I made a written comment on Sean's evidence of this morning, and if you will allow me I would like to read it to you. I wrote the following:

> "I would like to add my appreciation to that of the TRC for the courage and the willingness of Sean to give evidence at this hearing. I found his evidence to be honest and genuine of how he experienced his period of national service in the South African Medical Service. I also share the concern expressed by some of your Commissioners with regard to a number of issues that he raised.
>
> There are, however, a number of impressions and perceptions that are incorrect and that could be explained. I would like to request the TRC to allow me and my Headquarters to examine in detail all the aspects of his testimony in an effort to clarify these aspects that are incorrect and to confirm those that are correct.
>
> With regard to his final recommendation request to the TRC for the establishment of a Council of Post-Traumatic Syndrome I would like to support this concept.
>
> Indeed the South African Medical Service had recognised this need in 1987, as I have indicated in my submission, and in fact launched a number of initiatives to deal exactly with this need with respect for the creation of a memorial where such post-traumatic stress syndrome cases could mourn and commemorate with the families and friends, there is already such a memorial standing in front of 1 Military Hospital.
>
> I find this also in harmony with what took place in the Defence Force when I took over command and when we started with the whole development of Project Curamus and eve-

rything that has stemmed out of that.

One of the elements that was addressed was the erection of the monument at 1 Mil which I have just mentioned.

I have arranged with Glenda already to provide us with the detailed testimony of Sean so that we can examine any of the issues that needs attention. I have also invited Sean personally to visit my headquarters so that we can discuss some of the ideas that he has expressed".

So please when you say that I have indicated that I am proud, I certainly did not mean it in the way that you have apparently taken it up.

DR WENDY ORR: Thank you General Knobel. Please just take into consideration as well that Sean is one of thousands.

GEN KNOBEL: I know.

DR WENDY ORR: Glenda.

MS WILDSCHUT: I just need to say thank you to General Masuko and General Knobel and Brigadier van Rensburg for coming today. And to all of you who have been here we have been through a long gruelling day. We have heard testimony that has made us sad, made us disappointed, made us ashamed, testimony that has also made us happy and proud, and hopefully we will take into account the spirit in which this hearing has been conducted today.

The hearings today and tomorrow are a genuine attempt for us to look very critically and very squarely at our past so that we can ensure that this is never ever repeated again.

Thank you very much for coming, and thanks for your patience and your tolerance. It's been a long day but we hope that you have a relaxing evening and that you come back tomorrow morning refreshed at 08H30 so that we can start early and finish the submission for the rest of the day. Thank you very much to everyone.

DR WENDY ORR: Also just to announce that the revised programme for tomorrow is available outside the doors, and 08H30 is when we start.

HEARING ADJOURNS