

TRUTH AND RECONCILIATION COMMISSION

HEALTH SECTOR HEARINGS

DATE: 18 JUNE 1997

HELD AT: CAPE TOWN

DAY 2

CHAIRPERSON: Can I welcome all of you again today. We had a very long session yesterday and I hope that we will be able to cut down on the proceedings today. I want to hand over to Dr Ramashala who is going to be making some opening remarks and then I want to follow that up with some points on today's proceedings.

DR RAMASHALA: Thank you Chairperson. Good morning everybody. This morning I thought I would set the tone so to speak by remembering those doctors who couldn't walk away from it. I think this is an important occasion to help us do a critical analysis of our past behaviour and I say more broadly, particularly in the field of human rights, to do an honest assessment, not only looking at individual behaviour but also examining those policies, structures and procedures that enable the perpetration of those gross human rights violations, particularly in the health sector.

First I want to pay tribute. Dr Mvuya Tom, Dr Abe Nkomo, Dr Aaron Mac Claury(?), Dr Rafiek Ismaela(?), Dr Ndeleza Mjee(?), Dr Joe Viriaver(?), Sister Madelaine Tshabalala, and many many others of you for whom the floor was frequently your surgical table, for whom improvisation was your practice art, for whom life was very dangerous just by the act of intervening. Many of you were detained just for intervening, many of you were tortured, many of you were harassed.

My tribute to Black doctors is not to take away or demean what was contributed by doctors in the broader South African community, but it is a special tribute because they couldn't walk away from it you see, they were part of the morass, part of the pain, part of the struggle and overriding all of that was the question of caring even under very difficult circumstances.

To all South African doctors, both Black and White, it is arrogant of me to remind us that caring is more important, much more important than State objectives, that our patients are much more important

than the security of the State, and that perhaps as we look to the way forward that we'll learn from our past experiences and our past behaviour and that we make a strong strong commitment that our patients come first.

I want to read some excerpts from some of the letters we received, and this will be done throughout the day, just a few excerpts. The first is from the Harvard School of Health, Centre for Health and Human Rights.

“The Francois Xavier Centre for Health and Human Rights at the Harvard School of Public Health supports the process of examination and the search for the truth. The systematic structural conditions which enable human rights or violations to go unchecked must be brought to light. We believe that the call for accountability by the health institutions and professionals will serve as a model for such work around the world. Knowing that this process will be painful and difficult at times, but ultimately will create an environment in which all live from human rights violations is what makes this endeavour so worthwhile. We extend our utmost support to the work of the Commission”.

An excerpt from Johan S.Veer Stigting (?) Foundation for Health and Human Rights,

“We believe that your hearings will constitute a milestone in the history of the health profession which surpasses the interests of South Africa. We wish you much success in conducting these hearings”.

An excerpt from the World Federation of Mental Health:

“It is regrettable that the WFMH is unable to directly be represented at the hearings, but I am sure that the members of the Federation worldwide will await with keen interest to hear about the outcome of the deliberations. On behalf of the WMFH I wish to extend the strongest support to the hearings. We trust that your deliberations will be fruitful and assist in the process of reconciliation in South Africa. I have no doubt that the WMFH would be more than willing to participate in any further activities initiated by the hearings”.

And finally for this part of the morning, a letter from the Province of KwaZulu Natal Health Services, the Minister's Office:

“We should be especially vigilant in the health care field. Our aim must be to always provide care and comfort for those who turn to us for help. We must ensure we are not maltreated, abused or corrupted by their contact with us. To be able to do that we have to be aware of the shortcomings of the past, of how systems have been manipulated and what motivators drove the causes of evil. We need the truth, not for retribution but for reconciliation and for the capacity to build a better system, better processes and procedures so that the people whom the health sector serves are accorded the attention and support they deserve. It is my hope that by exposing the short-comings of the past, we’ll be able to create a future in which all health care providers are viewed with trust as people of compassion, integrity and skill.

I wish you all the very best in your deliberations today.

Chairperson, excerpts will be read throughout the day from all the different letters we received and thank you very much.

CHAIRPERSON: Thank you Dr Ramashala. Can I call the MASA delegation to the table. And whilst they are doing that can I say that after yesterday’s experiences we are going to be fairly strict today. I know everybody in the audience does not have the respective submissions being made. So I’m asking the delegations to cover the important points in your documents. Time limits have been set down on the timetable and I’m going to actually be fairly strict on keeping people to those times today for several reasons. I certainly don’t think I want to actually have a situation like yesterday where we’re going well beyond our time.

Secondly, many of you have come here today to participate in the workshop at the end of the hearings and I’m sure many of you want to get back to your respective homes. So in order to give that meeting the respect it deserves, we need to finish all the proceedings at the right time.

So please don’t be affronted if I intervene when my colleagues and panel are leading you but I don’t think we’re going to get through the timetable unless we do that today. Thank you very much.

MASA SUBMISSION

Dr Barker, I welcome you and your delegation. Perhaps you can introduce all of them to us before

you stand to take the oath.

DR BARKER: Thank you Chairperson, Dr Bernard Mandell is in fact the chairman of the Medical Association and we're prepared to be (speaker's microphone is not on) and on my left is Dr Hendrik Hanekom who is Secretary General and to his left, Dr Dan Ncayiyana who is the editor of the South African Medical Journal, who clearly is very closely, the journal itself, is very closely associated with the activities of the Association throughout all the years, and I think Bernard is going to start the proceedings with a brief introduction and then I'll take on as far as the submission is concerned.

CHAIRPERSON: Is there a possibility that the others may speak as well just in terms of taking...(intervention)

DR BARKER: They are here just in case there are questions which are posed to us by the Commissioners which they are perhaps in a better position to answer. They are not making submissions themselves, they are here in case of questions.

CHAIRPERSON: Sir can I ask all of you then to stand I will assist you in taking the oath. Glenda will you do that?

DR RAMASHALA: Could I ask you please state your names for the record before I administer the oath. We'll start with Dr Mandell.

DR BERNARD MANDELL: (sworn states)

EDWARD BARKER: (sworn states)

HENDRIK ANDRIES HANEKOM: (sworn states)

DANIEL NCAYIYANA: (sworn states)

CHAIRPERSON: Thank you, Dr Mandell, you may start.

DR MANDELL: Thank you very much Chairperson, Councillors, thank you very much for giving us the privilege of being with you at this very important occasion in the last two days. We are extremely concerned about the past and spending the whole day with you yesterday it was something which all of us have thought about very deeply before and do so now as well. I am, as Dr Barker said, the Chairman of the Federal Council of the Medical Association. I also have the privilege of being the president of the World Medical Association.

MASA is a voluntary professional organisation of medical doctors. There are approximately 27

000 doctors registered with the interim National Medical and Dental Council at present, some 21 000 of these are practising doctors and 14 000 of them have chosen to voluntarily affiliate with the Medical Association of South Africa. The Association's mission is to empower doctors to bring health to the nation. The association must certainly not be confused with the Interim Medical and Dental Council, a statutory body in place for the State to protect the community through licensing education and the maintenance of standards with disciplinary powers to act against doctors for unprofessional conduct.

On the 24th of January 1996 following an international meeting on the caring of survivors of torture which took place in November 1995 which I've tendered on behalf of both MASA and WMA, the Secretary General of MASA wrote to the TRC as follows:

“MASA wishes you and the Commission every success in achieving your objectives. One tragic event was the death of Mr Steve Biko. MASA does not have any specific new information. However should it be required MASA will be pleased to cooperate in giving the Commission access to all records and documentation at our disposal, or make such available at your request”.

The first current collection of important documents surrounding MASA and Human Rights was published in an article in the South African Medical Journal of September 1996. Immediately following the publication MASA approached Miss L Louw, a master of Philosophy student with an honours degree in Psychology as its researcher. Ms Louw was given carte blanche to go through any of the MASA files and archives to gather any material related to human rights. After four months she collected a substantial amount of documentation which was presented and is presented today in MASA's submission to the TRC. MASA members have been on both sides of the spectrum, some have been perpetrators of human rights violations and others have been victims. Some have campaigned to advance human rights and others have been complacent. The complete submission attempts to cover the role which MASA as an organisation played in Human Rights development.

Just briefly I want to mention the question of the World Medical Association and MASA and I want to refer to the visit of the World Medical Association to Somerset West last October and the opening address by Mr Thabo Mbeki, the Deputy President of South Africa. He said,

“In June 1995 the Medical Association of South Africa adopted a resolution with unre-

served apology to persons within and outside the Medical Profession who might in the past have been hurt or offended by any acts of omission or commission on its part in the past”.

In his statement the chairperson of the Federal Council of MASA mentioned some of the issues on which MASA has remained silent and had been insensitive and indifferent and went on to commit MASA to broadening access to quality health care for all the people in South Africa.

It was an important announcement and MASA deserves credit for having made it. The point was also correctly made that the notion that it should be a beacon pointing the way to the completion of our transition, indeed much work remains to be done merely to deal with the legacy of the past. And that serves why we're here today.

I'd like now with your permission to ask Dr Barker who's our main spokesman in the submission. Thank you.

DR BARKER: Dr Randerera, Commissioners, forgive me if I read again. This is for the sake of keeping within time and to ensure that we get my message across exactly as I want it to come out.

At the outset of today's proceedings concerning the Medical Association of South Africa, I would like to make a personal statement regarding my own position in appearing before you to present the Association's submission. My position here could be seen by some people to be equivocal and I would like to explain why I have accepted personally this onerous and rather necessary task. The present day MASA has taken upon itself the task of examining the history of the organisation in an effort to uncover and disclose human rights abuses which arose by commission or omission by the MASA under apartheid.

As one of the members of the Association who was active at the time in opposing a range of decisions and policies of the MASA as it then existed and in the period covered by this submission, I am in a position to explain and elucidate to the Truth Commission the matters covered by the submission document.

The membership of the present organisation, approximately two thirds of whom were not even qualified at the time of Steve Biko's death, have taken on responsibility for examining the darker side of the history of the Association. While the MASA of today is a vastly different institution from the MASA as it existed under the period of examination, the present membership recognises that the history which it

has inherited requires full exploration and disclosure. Collective responsibility for this history has to be accepted before the organisation can be freed of the burden of the past and move forward to fulfil its role in the life of the community.

Before I go on to address the substance of our submission document, I would like to make one extremely important correction of fact relating to something that appears in our submission. It relates to the decision by the Federal Council of MASA in 1974 to prohibit the South African Medical Journal from accepting advertisements for professional appointments that can contained any terms discriminating between doctors on grounds of race or colour. This is mentioned on page 37 of the document. However paragraph two on page 38 states that MASA decided to amend rule 19, which was a rule limiting advertising for professional appointments to professional journals only. The documents state that this amendment was made by MASA in order to ease the difficulties for the government which was then unable to advertise State posts with a racial criteria.

Now this is a grave error. This fact is simply not what happened. Rule 19 was in fact a rule of the statutory body, the South African Medical and Dental Council and it was this body which amended the rule in order to rescue the government to allow it to continue making discriminatory appointments. The MASA stuck to its policy and since 1974 has never again accepted discriminatory advertisements.

Now I make this correction, not because I believe it's part of my submission today to tell you about any of the good things which MASA has done in the past, MASA has done some good things, this is not what we're concerned with today, the only reason I have made this statement about this factual correction is that I believe it's equally important that MASA not be asked to accept blame, guilt for things which it did not do, such as for example the impression created by this.

And now Mr Chairman, to go on to my main presentation. It's not going to be possible for us, there's a 104 pages of detailed fact in the submission and there is no possibility in the time available for me to cover this. What I want to do is to give an overview of what we have tried to do, how we approach the subject, what our intentions are and then make as much time available as possible for questions from the Commissioners who would like to elucidate matters and we'd be very happy to answer.

Now MASA as such was always, without doubt, a part of the White establishment in South Africa, and for the most part and in most contexts it shared the world view and the political beliefs of that

establishment. Inescapably it also shared the misdeeds and the sins for which that establishment was responsible. From the time of its inception in 1927 until the day that Steve Biko died, the Association flirted along in terms of human rights and its approach to human responsibilities in a fairly unconscious and unremarkable fashion with a few issues being taken up such as, for example, its repeated calls for the abolition of discriminatory differences and the salaries paid to doctors of different race groups. These efforts were not immediately successful, it took many years to achieve parity.

Apart from these the Association in general was quite comfortable with the status quo and its public reaction to any criticism of the inequity and the iniquities in society, particularly the inequities in health care delivery was to dismiss that criticism as the work of enemies of the State and defined all sorts of means to defend itself and the system.

The death of Steve Biko, and particularly the circumstances surrounding his death, in which members of the medical profession were clearly and shockingly involved was the event which rocked this complacency and started to force the Association to examine the ethics and the morality of its actions in many different contexts.

The Association was initially able to resist calls from within and without its ranks and for the actions of the doctors concerned in the Biko death to be investigated and judged on the grounds that an inquest was to be held and that justice demanded that any action that preempted this inquest would be unjust. When the findings of the inquest magistrate were released, the clamour started up again for MASA to take action in the name of the honour of the profession and its claim to be the upholder and guardian of professional ethical standards.

The Association again resisted these calls, again on the grounds that the matter had now been referred to the Medical Council for investigation and was therefore still sub judice.

When the Council finally, two and a half years later, issued the findings of its committee of preliminary inquiry which, astonishingly, and unbelievably, absolved the doctors concerned from any blame, the fires of controversy really flared up. Under growing pressure from vociferous protest, among which I participated fairly actively, again from within and without its ranks to publicly reject and to condemn the Medical Council's indefensible finding, which seemed to simply ignore the evidence given at the inquest, the Association was finally faced with its moment of truth. It had the opportunity to rise to the occa-

sion and to meet the challenge to demonstrate its commitment to truth, to equity, to justice and the centuries old tradition of professional honour. It not only failed to respond to the challenge and thereby betrayed the values for which it supposedly stood, but the leadership of the time then mounted a vigorous nationwide propaganda campaign to make sure that the membership of the Association followed its lead in this matter.

However, this sad and disgraceful episode marked the beginning of a movement within the Association, a movement of opposition to the actions and attitudes of the then leadership of the Association which haltingly and with many setbacks and failures finally grew powerful enough so that by 1989, it was quite clear that the Association had set its feet firmly on the road of renewal and transformation.

Our written submission details the many failures and compromises that occurred along the way, failures of will and courage, compromises founded on expediency, many of these occurring even in the years since 1989. It's not possible in the time available today to explore in detail all the misdeeds of commission and especially of omission that have been detailed in our written submission. However I can assure the Commission that we have made every possible effort to provide as complete and as honest a disclosure as it lies in our power to do.

I plead with you and with the Nation, that this submission be accepted with respect for the truth which it embodies. It is vital for the Association, at this point in its development, its renewal and its transformation, to achieve reconciliation, and this can only happen if there has been full disclosure and full acknowledgement of all the wrongs of the past. If there are gaps or omissions in this submission, they are unintentional. We would welcome any input in this regard from whatever quarter it may come.

The transformation of MASA of which I speak is an ongoing process. A significant event along the way was the unconditional apology for the past wrongs of the Association that was made in June 1995. We stand by every word that was spoken in that apology. However there are those who understood this apology to be an attempt on the part of the Association to achieve what they termed blanket amnesty and to sweep everything else from our past under the carpet. This was far from the intention of that apology. The apology was a necessary step along the road we are travelling, but it was only a step. Our wholehearted participation in the work of this Commission is yet another step on this road, but again only a step.

In terms of the way forward there is much that we have done to make sure that the wrongs perpe-

trated in the past by doctors can never occur again, but there is much that remains to be done. We intend to participate fully in the work of the proposed over-arching Health and Human Rights Organisation. We propose to enlarge and to strengthen the office and the activities of our ombudsman, our public protector. Our peer review system has already been sharpened and structured much more effectively than it ever was before. We are currently engaged in a programme designed to promote structured ethics education in all the medical schools in this country and we are planning formal structured training for prisons' health service personnel.

However, in all these efforts we still find ourselves hampered by the huge baggage of past wrongs that the Association has had to drag along with itself and from which it has found it impossible to free itself. It will only be through the process of truthful disclosure and reconciliation that we will finally be freed from the burden of this baggage.

And Mr Chairman I now would welcome questions.

CHAIRPERSON: Thank you Dr Barker. You've been very disciplined in putting your ideas forward.

Dr Barker as you know I've already submitted a number of questions to the Medical Association. I think there are other questions that we would like to submit in due course, but again, and I don't want time to become the only factor today, so I'm going to actually ask a few questions and then hand over to my colleagues.

My first question is related to your apology. As you know within the South African Medical Journal a number of people have already criticised that apology as being superficial as not taking into account real disclosure but referring to generalities. I wonder how you would respond to that?

DR BARKER: As I said in my presentation Mr Chairman, that was a step along the way. It was a statement of intent and it was not meant as I said, to be a plea for blanket amnesty or an attempt to simply close the door on the past without examination.

The opportunity to examine and really to come to terms with our past, to explore it fully has only been provided by the existence of the Truth and Reconciliation Commission. I think you would agree with me that, but for the existence of this Commission, it would have been somehow not even possible to spontaneously and for ourselves, go into this exercise of self-examination. We are so grateful for this opportunity because without it we couldn't have carried forward.

CHAIRPERSON: Can I just follow it up Dr Barker and ask, does the apology include, or can you respond to the idea that MASA, quite often you mention yourself that 1989 perhaps was the final breaking point in terms of your declarations, but many individuals during that period and other organisations who stood up for help in human rights were criticised within MASA and within the South African Medical Journal, does the apology also include some of the remarks, statements made by MASA in response to those groupings?

DR BARKER: Yes Mr Chairman it has to do so in view of our urgent drive towards unity throughout the profession and the closer and closer negotiations that have been going on over the past two years between ourselves and these very people whom in the past we regarded as our enemies, whom we criticised, whom we kept at a distance, attacked. Yes we are and have been for the last two years, approaching them and are coming closer and closer, we are now at a point where I can see a very real possibility that within six months the profession as a whole in this country will be united under one umbrella organisation. So that this is a necessary part of that apology.

CHAIRPERSON: Dr Barker I want to just come to one point of the segregated hospital issue, the separate facilities for training. In your own document you refer firstly to a resolution that was passed in 1970, I think by the Tanzanian Medical Association at the Commonwealth Conference and then subsequently a resolution passed at the 1973 World Medical Association again critical of what was happening in South Africa in terms of health services and the role that the organisation played. Now both you and Dr Mandell have been part of this organisation for a long time. We need to understand what happened in that period. Dr Ramashala has already referred to the responsibilities of health professionals being one of caring and speaking out when that is being contradicted.

Given, and again going back through your document, there was a letter written by doctors from the Medical School in Natal in the '60's, raising the question of discriminatory practices. I accept that you say that the organisation has always been open in terms of its membership, but yet there were glaring examples throughout this 29-year period that we're talking about, and why was it that it actually took the Association such a long time to come out with clear policies when you were clearly interacting not only within the country but outside the country as well. I accept again when you say that other medical associations also didn't take a political position on issues, but yet at these international conferences MASA was

being criticised, can you comment on that?

DR BARKER: Yes Mr Chairman, as I stated at the beginning of my presentation, MASA was essentially a part of the White establishment with, and it shared by and large, not entirely, but it's membership by and large shared the world views, the political views, political attitudes of the White establishment in this country which regarded the sorts of criticisms which you've mentioned as motivated by enmity to the country as part of what later came to be known as the 'total onslaught'. The total onslaught mentality was certainly extant and operative in the White South African context in those days and the explanation for this lies in an understanding of where the White population of this country stood in relation to all these matters.

The other point is that it took a long long time for those of us who recognised the difference between problems of ethics and morality and problems of politics, but there was a vast difference between the two large numbers of members. Very large numbers of our members for a long, long time failed to see any difference. A political stance, even though it might be based upon what moral basis, if it was antagonistic to the current status quo, the actions of the country or particularly the Association or the Profession, this was regarded as an attack and was opposed with vigour. This of course was completely wrong. It was not what doctors should have been doing, but it took a long, long time, certainly up to 1989, before those of us who had for years been trying to make the right noises and persuade the Association that ethical behaviour in relationship to the population it left their patients in relation to the structure of health care had nothing to do with politics and should be a concern of all members of the Association no matter what their associations. It was only from 1989 onwards that we had sufficient support among our membership to be able to drive this forward.

CHAIRPERSON: Thank you Dr Barker. May I ask Dr Hanekom who would like to speak?

DR HANEKOM: Just to add to what Dr Barker said, on page 95 of our submission I think there is a specific answer to your question which is very clear that these deeply ingrained discriminatory attitudes pervaded our society and MASA did not escape them. MASA tolerated a system in which doctors treated patients and colleagues differently based on the colour of their skin. MASA was so wrapped up in its White male elitist educated professional world as individuals and as a collective organisation, and as part of a broader society from which doctors were drawn, that it failed to see the need to treat all people as

equal human beings. Perhaps the same could be said of other groupings in society. MASA allowed Black and White people to be treated differently and this is the form of human rights violations for which it stands disgraced. I think it's very clearly stipulated in where we come from and I think this part of our submission also answered the question that you raised.

CHAIRPERSON: I want to come to the question of Mr Biko. I know from your submission and reading the journals, your branch and you yourself were very vociferous at that time, but you were saying in your earlier statement that there seemed to have been major outcry at the time within the Organisation. But yet when it came to the actual vote within and supporting the initial response of the South African Medical and Dental Council, the organisation came out in support of that initial decision. Perhaps you can just give us more details on your own experiences and your feeling now on how the Organisation responded?

DR BARKER: I think this part of the history is very important in an understanding of where MASA was in those days and how it came to be that it did the things it did and failed to do the things it should have done. There was a very strong leadership, there was close association between the top leadership of the Medical Association, the - can I say the establishment certainly a close association between the MASA leadership of the SANDC and without any doubt in my own mind I'm convinced that there was close association, certainly with various structures in the government and certainly with people in the government on a very personal basis. Now the leadership at that time, I believe, felt, were told, felt for themselves that if these doctors were to be found guilty it would create such a furore for the Health Department and for the Government itself, for the Security Police, for everything that it had to be damped down and smoothed over as effectively as possible.

Now there was a huge outcry and as you say you've read the journals, there were letters from all the provinces, from all the branches, lots and lots and an enormous amount of correspondence received by the journal which has only now this month been published, a whole lot which was not published by the journal, load of letters and the then Chairman of Council undertook a whistle-stop tour of all the branches in the country, he addressed them all making an impassioned plea to the membership please to support that they couldn't possibly question the integrity of people on the Medical Council. It was unthinkable that doctors of that standing could remotely have their integrity impugned, which was these wild people writing these subversive letters were trying to do.

He managed to convince meetings held at every branch to express support for the position of the then MASA executive with one exception, he came to the Natal Coastal Branch and this was the only branch in the country that refused to accept his plea that while he was there, rejected, passed a resolution rejecting first of all dissociating itself from the SAMDC finding and rejecting the action of the executive in approving this, demanding that the executive in fact altered its stance, and this was basically an explanation of what was going on then.

DR MANDELL: Mr Chairman I'd just like to add something to it. The specific reaction at the end of the day and what the Federal Council did, and this was in the early days when I had become a Federal Council then was the special meeting of the Federal Council which was held on the 12th of November 1980 to discuss these issues and what the reaction of the Federal Council was going to be to the outcry of which Dr Barker speaks. There was a considerable debate and one must also remember that there were four members of that Federal Council who were also members of the Medical and Dental Council at that particular time, one of whom was the chairman of the Council too, and they paid considerable attention to what those councillors, the members of the Medical Council had to say at the meeting of the Federal Council. There's no doubt whatsoever that the Federal Council was attempting to avoid a direct confrontation with the South African Medical and Dental Council for the major reason and that was the destruction of the Medical Association itself, if they had adopted a policy at that stage of condemning the Medical Council. They didn't face up to it, and I was one of them at that particular time, didn't face up to the reality of this. Each one of the members of that Federal Council represented a branch, it was purely at that particular time branch representation. They represented the interests of those particular branches and as we rightly have here, the outcry came from certain branches, but at the other branches they wished to maintain the status quo and not upset anything that might have happened, whether it was government inspired or whether it was the Council itself. They did not take that action, they found a compromise, what they believed was a compromise to examine detention, to examine children in detention, and that was as far as they were prepared to go to accept some committee which would examine these issues rather than face the possible destruction of the Association.

CHAIRPERSON: Thank you, my last question and then I'll hand over to my colleagues and it's to do with racism. It was only in 1994 that you finally made a decision on separatist rooms that doctors had for

examining patients. What has the Organisation done since then? Because I'm sure none of us will disagree that racism still remains within our society, what has the Organisation done to eradicate racism and to what position would the Organisation take today if it was brought to your notice that some of your members was still practising in this fashion?

DR BARKER: Mr Chairman could I just go back a little bit before 1994, from 1990, at that time the then Minister of Health set up quarterly meetings with the executive of the Association that later became the Board of Trustees and at every one of these meetings the Medical Association Executive brought forward its demand to the then Minister of Health for the abolition of the fragmented Health Services, the abolition of the 14 Ministries of Health and their unification on the one hand, and on the other for the opening of all hospitals to all races, the abolition of the racially separate nature of State hospitals. That was our position from 1990 onwards and a demand which we made repeatedly and it was only finally acceded to by Minister Venter I think in about 1993, that she finally conceded and the hospitals throughout the Republic were open to all races. I think our stance today would be unequivocal rejection, and I really don't believe that we could maintain, within our membership, people who overtly and clearly were practising in a racist way. I don't think that this could be conceivable particularly in the light of our move towards unity with the entire profession in the country.

CHAIRPERSON: Over to my colleagues. Pumla.

MS GOBODO-MADIKIZELA: Thank you Chairperson. Gentlemen I really find your comments, the forthrightness, the frankness and openness very refreshing. I think that you have very clearly illustrated what the evil system of apartheid did to many of the structures that were supposed to be promoting health in our society did not do, and I really appreciate that openness that you have demonstrated.

My question to you is about the South African Medical Society, SAMS in the military. Did MASA have a relationship with the South African Medical Services in the military and if so, what was the nature of this relationship?

DR BARKER: I am unaware of any but I could ask my colleagues. I'm not aware of any formal structured relationship with SAMS.

DR MANDELL: That's quite correct, we didn't have a formal structured relationship other than the odd invitation to a military dinner ...(intervention)

MS GOBODO-MADIKIZELA: ...hobnobbing with the military.

DR HANEKOM: That's correct yes, but no other specific formal relationship. Probably what you're leading up to say is, why didn't we examine that relationship and try and find out whether there was any discrimination there in any way?

MS GOBODO-MADIKIZELA: Not so much questions of discrimination but really from the point of view of the medical profession being custodian of all medical ethics and medical practice in the country, I would assume or would have assumed that you were the sort of guardians of those kinds of organisations. So I'm surprised to hear that in fact you did not have any relationship.

DR MANDELL: Well there are two ways of looking at it. Firstly the question of us not being a statutory body and then obviously it would be the Medical and Dental Council which should look after the interests of the soldiers in the army and others within the army to see that their rights were respected despite the fact that they happen to be part of the military, and to take any action that might be necessary. And certainly as an Association and if we were aware, obviously aware of any discrimination of any sort within the army, well then we should have taken it up. But Dr Hanekom may have a little more information from the point of his being the secretary general and had a more close relationship with those in the army. Possibly he may want to answer differently.

MS GOBODO-MADIKIZELA: Yes thank you.

DR HANEKOM: Thank you Dr Mandell. Commissioner although there's no formal relationship, there is on the one Committee of the Medical Association, the committee for fulltime practice there is a fulltime representative from the South African Medical Services, representing the military doctors on that specific committee. That committee deals more with terms and conditions of service. There's always been, although not a formal relationship, a very open relationship between the Medical Association and the South African Medical Services, always when there were specific problems and I can't remember the specific dates but there were at one stage quite a few problems. Doctors had certain problems, they approached us, we then approached the Surgeon General or his office and I must say that most, at that stage it wasn't specifically about human rights issues but problems that people experienced or people that couldn't, were called up for service, that couldn't, because of family reasons, we had a very open relationship and I can't think of one opportunity when we had to go to the military that they didn't do what they

could, but we didn't have any specific, human rights-specific issues that we took to the military.

MS GOBODO-MADIKIZELA: Yes, Dr Barker.

DR BARKER: There is something that I want to say also in reply to your question, Madam Commissioner and that is again to draw your attention to the fact that it was a slow process. The move of the Association to an awareness of its responsibility in terms of human rights, in terms of its social responsibility, its responsibility for the welfare of the community rather than the welfare of doctors, and it was really a slow development and certainly very recently only have we started to be proactive rather than just reactive to matters of ethics and human rights and that sort of thing. We now are an Association that has a large part of our activities devoted in this direction, but this is a very recent development.

MS GOBODO-MADIKIZELA: I had in mind the submission yesterday by a person who was in the military, who was a military medic. I don't know if you were here yesterday, who told us about the training of a military medic which clearly illustrates a violation of human rights and a violation of medical ethics, where they were trained or they practised, as you said, on Black patients in Tembisa and another hospital, I think it's Atteridgeville, and that really was what I had in mind and I wondered if those are the issues on which you would exercise your pro-activeness in just investigating, having heard of how things are done?

DR BARKER: Madam Chair, I would say I was here yesterday and I heard the submission and being just a member of the audience I was not able to comment, but I do know that all paramedic personnel, whether they be in the ambulance services, whether they be within the hospitals, whether they be in the military, whatever, all paramedical people including nurses undergo training in simple wound management in all the hospitals, Black, White wherever. Every hospital where I have ever been, in the casualty department have been students, medical students, nurses and paramedics of all sorts, including military medics, not practising, who are being trained. Their subjects, victims if you like, have been patients of all races in all hospitals. And I really mean this in every hospital I've worked in.

MS GOBODO-MADIKIZELA: So just for the record so it is incorrect to claim that the practice or the training of these medics at the Black hospitals has anything to do with the colour of the patient, it's incorrect?

DR BARKER: I didn't regard that as a violation, no.

MS GOBODO-MADIKIZELA: Okay thank you.

MS WILDSCHUT: Gentlemen, I'm allowed one question and I'll try and ask this question quite quickly. I can't resist asking whether MASA had any relationship with the Broederbond and if so, what kind of relationship there was?

DR BARKER: The answer to that is in terms of what we know, no, the Association as such certainly had nothing to do with the Broederbond in any way whatsoever. However, it remains my strong conviction that the relationship that I spoke about earlier, which I personally found quite, quite wrong way back at the time between the leading members of the Medical Association, the leaders of the Association, the people who really sort of set the tone, set the policies, persuaded the membership to come in this or that direction, the relationship between those people, between the heads of the SAMDC and between the people in the Department of Health particularly and other areas of government, particularly this I have no doubt the Security Police as well, my own belief, and it is completely unsubstantiated, was that that was based upon Broederbond membership. This is something which I can only say was an opinion which I held and I have no evidence for it.

MS WILDSCHUT: Thank you very much.

MS MKHIZE: Just one question from me. I was just going through your document, looking at your section where you talk about MASA and human rights violations, looking at different paragraphs, to me it sounded like a very difficult position to comprehend as to exactly what is your position. In some section you talk about MASA has not committed gross human rights violations, and in others you look at the different degrees of conspiracy, complicity, and even of human rights violations, MASA was not any time directly involved in conspiracy or complicity. There are different sections where one picks up this contradiction as to what exactly is your position.

My specific question is that under this section where we look at MASA and human rights violations, in view of the fact that we are at the phase where we're all working towards transformation but the essential stage is the establishment of the truth, I would have liked a document where you have made a careful assessment of what went wrong and actually documented, as a vehicle for transforming this professional grouping, and I think that would be very, very important in view of the documents whereby other organisations like NAMDA and other progressive structures actually embarked on a campaign interna-

tionally that MASA be one of those professional bodies who should be isolated. So I'm just looking for your position where you think things went wrong.

DR BARKER: Madam Chair, I think at close reading, I don't know whether you've had the opportunity of reading the submission in detail, but I think if one goes through this in detail, some of the statements that you mention like MASA was never sort-of involved in this or that, these are in quotes, these are statements which were made by responsible MASA spokesmen at the time which we now publish with frankness as being things which we would certainly not today say. It's very difficult. We have done this job as completely as we believe it's possible to do and really I believe it is a very complete document, it is totally, totally revelatory of everything we have been able to find and as I have said, if there are omissions or shortcomings, we would welcome being filled in. What I am uncomfortable with is being told that no it's not good enough, it's incomplete. I want to know if there is further information available to anybody that we have not included in this. This is what we are asking for, for input. We have given everything we've got. More than this we don't have, but if there is more, we plead that it be brought to us in detail so that it can be incorporated in our final document, remembering that this document as it stands is - my only criticism of the document is that it is patchy. There are large sections where it is not quite clear what the context was in which certain actions took place and I believe as a history of the time it's going to need some very skilful professional editing and in the process may well need the insertion of further facts that have not appeared but beyond that Madam I don't think we can do.

DR HANEKOM: Mr Chairman can I just maybe, I don't think there is any specific contradiction in specifically the section on MASA and human rights violations. I think it's stated very clearly that the mandate of the TRC has been to examine gross human rights violations. The Act on which the TRC is based defines gross human rights violations as killing, torture, abduction etc, which is politically motivated. MASA has not committed gross human rights violations as per this definition.

What we further said is that MASA allowed Black and White people to be treated differently and it's this form of human rights violations for which it stands disgraced. So I don't think there's any contradiction or anything. I think it's very clear what we've said.

CHAIRPERSON: Thank you, Dr Ramashala.

DR RAMASHALA: On pages 86 and 87 of your document you very briefly refer to the problematic

issue of district surgeons. I'm also aware that you have a document from the AAAS which I believe addresses the issue of district surgeons in detail. It is also my understanding that you have a very active continuing medical education programme, am I correct?

On page 87, the second paragraph, this refers to the HSRC study work group investigating the operational effectiveness of health care services in South African prisons but my question is more general and my comment is more general. You state and I quote,

“The work group recommended the continued role of the district surgeon that efforts should be made to sensitise district surgeons to ensure that they respect the doctor-patient relationship in the prison context”.

I want to relate this to the broader context more than just the prison context. The issue of sensitisation is a very superficial issue, the successes in terms of sensitisation depends on voluntary actions of the participants, those people as we know about the history in the United States, those people who tend to be successfully sensitised are those who are already converted.

I have not examined the section, there's a section there on continued medical education, what I'd like to see is a stronger commitment, not just with respect to the district surgeons but with the medical profession in general, a stronger commitment that ties in into continuing medical education, the requirement for human rights education and training, but tied into continuing medical education credits and a much stronger commitment, much stronger than the superficial sensitisation requirement. Perhaps you might want to comment on that if I've missed it somehow?

DR BARKER: Yes Madam Chair. I did in fact mention it briefly in my presentation.

Some years ago the Medical Association, aware that there were gross sort-of episodes of misbehaviour, not just in terms of race and politics but simply of doctor/patient relationships. The frequency of gross violations of patients' rights of the numbers of doctors who fail even to understand the patient's right, the patient's right to information, to consent, all this sort of thing and the Association found the wide-spread nature of this problem to be very worrying and it has set up and has managed to engage all the seven medical schools. It is a MASA initiative, they are running a committee for undergraduate medical, ethical education and this committee consists of teaching representatives from all the medical schools and we are busy, we held a very large two day workshop last year in Cape Town devoted to the same thing

where we are developing techniques and structures which are going to be put in place in all the medical schools, some of them are more advanced than others, but this is a MASA initiative and without this there are many medical schools who would today not be even thinking of educating their students in ethics. We are taking this extremely seriously.

I agree with you that it is important also in the continuing medical education field and some two years ago our journal of continuing medical education was devoted, an entire issue was devoted to questions of medical ethics.

DR RAMASHALA: Just as a quick follow-up of that, the question I raised was based more on the individual approach, that is physicians' behaviours. I want to explore further the issue of the systemic approach, that human rights abuses, let me put this bluntly, the ill-treatment of patients is also related to how resources are allocated in facilities. That has not been addressed in your document and I'm not posing it as a criticism, but I'm posing it as a way to encourage you to be involved with the Department of Health in examining those factors within the system that tend to encourage this kind of behaviour at the individual level. In other words, the way resources are allocated, the way patients sleep in a ward, the resources that patients have, that tend to delegate a secondary level to patients and that encourage others to treat patients as if they are not human.

DR BARKER: Madam Chair, one of our most consuming endeavours over the last three years has been our contribution to the development of the National Health System which the present Minister of Health is desperately trying to put in place. We have made an enormous contribution to this. We have been intimately involved with the Department of Health over these years. We have produced huge really well-studied documents, recommendations covering all the fields that you have outlined. We have been involved in this as one of our major enterprises for the last, at least the last three years, so I would ask please that we do get recognition for that.

DR MANDELL: Chair, just a rider to that, in addition to that, health policy documentation, we commissioned the document on human resources by a Mr Nicholas Crisp some years ago and within that document are all the elements of what you are asking, in that human resource documentation.

CHAIRPERSON: Wendy.

DR W ORR: I don't have a question, I have a comment and a suggestion and this is about the MASA

apology of which a great deal has been made and of which very little has been made and I hear you say that it was a step in a journey. I don't think it was a big enough step or a step that has been followed up adequately. It's very easy to make an over-arching apology, it's difficult to look people in the face and say we are sorry, and I really feel that in the interests of reconciliation and moving forward that the Medical Association should consider making individuals personal apologies to those individuals and those organizations whom it vilified and whom it failed to support during those years.

CHAIRPERSON: Thank you, you don't have to respond to that right now, Dr Barker. Thank you very much for coming today. I hope you're going to be staying for this afternoon's proceedings and continue to take forward what's been said today and in the submissions that we've heard already, thank you again.

DR BARKER: Thank you.

SANC SUBMISSION

CHAIRPERSON: Can I call the South African Nursing Council and whilst they're taking their positions I just want to welcome some of our international guests and others who are here and I'd like people to stand as I announce their names if they are here so that others who are in the audience can get to know them as well. Dr Maria Pniel Khali, I hope I pronounce your name properly from the Medical Rehabilitation Centre for Torture Victims, Mr Hans Ransecht from Medical International.

From the American Association for the Advancement of Science we have Professor Robert Lawrence, Audrey Chapman, Marion Gray Secundi, Len Rubenstein, Vince Coppino and Professor Jack Geiger.

From the British Medical Association we have Professor Vivien Natenson; Medical International, Mrs Ursula Merck and the MEC for Health from the Free State, Ms S Nhlaba Bati. I'm sure that there will be other people that we will be welcoming during the day. Thank you very much.

Good morning Ladies and Gentlemen, can I please ask you to introduce yourselves and the organisation you're representing today.

MR GERMISHUIZEN: Thank you Mr Chairman. I am Frank Germishuizen the Registrar of the South African Interim Nursing Council and the three council members with me are Professor Wilma Kotze, the vice president of the Council, Ms Ethel Radebe, she's the chairperson of the Council's transformation committee and Mr Tchipiwa Maumela who's a community representative on the Council.

Mr Maumela and I will be doing the presentation, he will present the Council's submission and I will answer the questions which we received in advance and any other questions which might arise will be divided up between us as we see fit, and we wish to thank you for the opportunity of being able to appear before the TRC.

CHAIRPERSON: Thank you very much, welcome to all of you. Can I ask Dr Orr to assist you in taking the oath, if you will just stand and then Ms Wildschut will take over thank you.

FRANK GERMISHUIZEN: (sworn states)

WILMA KOTZE: (sworn states)

ETHEL RADEBE: (sworn states)

TCHIPIWA MAUMELA: (sworn states)

CHAIRPERSON: Thank you very much. Glenda.

MS WILDSCHUT: Good Morning, Mr Germishuizen and Professor and the rest of the delegation. I know that you have a written submission. You also have given me a written response to the questions that I sent you some time ago. Please feel free to go ahead and present your submission and then we will address the questions after the oral presentation. Thank you.

MR MAUMELA: Thank you. Honourable Chairperson, honourable members of the Truth and Reconciliation Commission, we from the South African Interim Nursing Council feel humbled to be allowed an opportunity to come and make the presentation we came to make today. My colleagues and I decided that I be the one to make the submission but that we, at the same time, should make this hearing aware that I make this submission as one of those within the South African Interim Nursing Council who represents the community. That is because amongst other things, the South African Interim Nursing Council stands for the interests of the community and therefore has set the means in place to solicit, accommodate and give expression to the needs of the community visa a vis matters of health, if not just matters of nursing.

Chairperson given the horrific picture yielded by the picture of our beloved country, which picture permeates all spheres of life and all classes of professions, it may well be conceivable that normal people will embark on a spontaneous effort to try and dissociate themselves as much as possible from the past.

Concomitant to such a mindset we find a tendency to spare people on in a campaign, a campaign to forget about the past, yes to forget all even before we get to fully understand what it is exactly that should be forgotten. We therefore come here today with a vivid realisation that denials, excuses and explanations will not take this country anywhere. At the same time we are thankful because today everybody can speak, reveal and uncover. Yes we are all free to speak today. The former oppressors and the formerly oppressed, all alike.

It is with that in mind that we wish to borrow the wisdom of on who was with us yesterday in this very room who once declared in years gone past and if he himself was quoting someone else, then I don't

know yet, but I heard him declare and I quote, “no one shall be free until all are free”. We note with an immense measure of gratitude that the very temporary failures of the past very strongly form a firm basis for the successes of today and the same shall apply for the future successes.

Oh yes, the temporary failures, more especially of those who tried from positions of weakness to fight against a tide, a tide that enjoyed the benefit of the wherewithal to oppress, to maim and to vilify, indeed to brainwash and to abuse, they risked their all to resist segregation, social biases, disempowerment and a whole range of other negative eventualities that of course would be denied from time-to-time. But today, through the grace of God, those temporary failures do not seem to stop in getting transformed into great successes, successes that now spur some of us on into speaking up.

Chairperson, nursing as a profession did not and perhaps could not have escaped this erstwhile wide web of racial biases. Nursing with its militaristic approach to both training and the shaping of the nurses work environment ended up perhaps like many other health-related establishments as one of the tools tailored to suite the whims of the authorities of the day. Consequently it should come as no surprise that the Nursing Council, from it’s own corner, also contributed in giving form and direction to these temporary failures that we speak about.

However Chairperson the evolvement of these temporary failures gives us such a strong feeling of redemption, it reminds us once more of the words of someone who once said, and I quote,

“It is better to fail temporarily even if it is a million times on a course that is bound to ultimately succeed, than to succeed temporarily, even if it is a million times on a course that is bound to ultimately fail”.

Chairperson, the South African Interim Nursing Council came into being in August the 23rd 1995, and we make the following submission primarily on behalf of former South African nursing councils. We also make the same submission on behalf of the nursing councils in the former areas of Transkei, Ciskei and Bophuthatswana. We note that we have inherited a process within which perceptions were created which suggested a perpetuation, if not support active or by way of omission of certain circumstances.

We further acknowledge and accept without justification that Council was influenced by the policies of the government of the day. This could have resulted in both a conscious and unconscious perpetu-

ation of those discriminatory policies and legislation leading to gross violations of human rights.

We are aware that Council was all the time morally bound to adhere to a strict professional approach to matters of nursing without allowing itself to be used as a tool of the apartheid machinery.

We also appreciate that Council could have at times exercised a free discretion on some of the issues. We therefore wish to apologise unreservedly, both for conscious and unconscious activities, that could have the effect of undermining human rights from time to time. We however acknowledge that some of the Council members have from time to time tried their best to rid the Council of any apartheid overtones but they would time and again be steamrolled into a collusion because of the circumstances of the day.

Having indicated our awareness of instances perpetuating apartheid, we wish to bring into light some of the known incidents by way of highlighting areas of failures and the areas of success vis a vis the Council under an apartheid regime.

Regarding failures, and I'll come up with failures resulting from legislation and policies:

1. As prescribed by the segregationist nursing legislation of 1957, Council kept separate registers and rolls in respect of different population groups.
2. Only White persons could serve within Council with a result that nurses of other colours could not participate in making decisions that affect their profession. See in that respect, Section 4, subsection 1(c) of Act No. 69 of 1957.
3. While Council was aware that there was segregation in health treatment along colour lines viciating against the Nurses Pledge, they apparently made no effort to protest against the system.
4. Where, with the aid of press reports and other sources of information, where through those sources we became aware that victims of accidents were denied emergency treatment on the same because for their colour, there is no evidence to suggest that Council made any effort to confront the situation.
5. Surrogate nursing councils were established by the Homeland governments without the consultation of nurses in homelands. These tended to undermine the professional status and international recognition of these nurses.

In other instances nurses in Homelands ended up having to pay dual fees to better their situation. Those councils commenced without any financial support to assist them. Whereas Council was not responsible for the formation of these surrogate councils, Council failed to protest against the fragmentation of the profession along tribal divides.

6. Council failed to react to gross inequalities in the provision of training facilities for various population groups.
7. Where inspection results revealed a dire lack of facilities at educational institutions and training hospitals, Council failed to do more than just bring this to the attention of the authorities. This situation was more prevalent in Black hospitals.
8. Where former political prisoners and detainees made allegations against nurses in prisons and other hospitals, the Council failed to conduct proper investigations. Council would investigate only if complaints were laid. We know now as much as we knew then that most of the victims would not have known how and where to lodge their complaints.
9. Council failed to create a user-friendly image in dealing with professional conduct issues. This resulted in a near militaristic approach to the situation of the nurse. In most instances nurses were not empowered to know and exercise their rights. Many could not afford legal representation. Seemingly many of them also did not trust the pro forma complainant to protect their interests.
10. From 1960 to 1978 Council continued to apply the Nursing Act No 69 of 1957. This Act had the effect of introducing harsh apartheid measures into the control of the nursing profession. For example,
 - a. Section 12(4) of this Act provided that separate registers and rolls be kept for different population groups.
 - b. Section 4(1)(c) provided that membership of the Council be limited to Whites. The result was that other racial groups were denied a say in matters affecting their profession.
 - c. Section 3 limited voting to White members of the Profession.
 - d. Section 49 made it a criminal offence for a White nurse to be put under the super-

vision of a nurse belonging to other race groups.

Regarding Communication. - The Nursing Council failed dismally in terms of communicating issues to the members of the Profession, the communities and all stakeholders. This resulted in the Council being seen as dwelling in an ivory tower remote from the profession and those it was supposed to serve.

Regarding Staff Appointments -

1. Appointments of staff in the categories of typists, clerks and upwards were almost exclusively limited to Whites. There was no deliberate effort at all on the part of the Council to empower members of the disadvantaged communities.
2. Although there was no deliberate policy promoting job reservation, Council's requirements for employment, namely the minimum qualifications being standard 8 for appointment as a typist clerk, and secondly fluency in English or Afrikaans, these things tended to exclude many would be and actual applicants who could otherwise have succeeded.

We felt that maybe it is a little bit worthwhile to make mention of some of the legal successes there have been down the years and we are very conscious that we do this at the risk of sounding a sort of jakkels prys sy eie stert kind of a note. But we felt we should do this because in every battle and in every struggle there is the concept of the unknown soldier who is not there to speak for himself, and we felt we should not end up undermining the efforts of those who tried because the features of the unknown soldiers are not much more in the successes but I think what should be taken into regard is much more the decision to try under very, very hard circumstances.

And I want to begin with the legal successes by way of excuse, Honourable Chair, but just for the record.

Nursing Education: Although the Council in terms of the Nursing Act of 1957 kept separate registers and rolls for the different population groups, its educational programmes were the same for all trainees, thus ensuring a uniform standard of education and training throughout the country. This standard is so high that South African-trained Nurses enjoyed international recognition.

The Council's Database: The Council has always kept an excellent database of details regarding all nurses, both in training and qualified. This is of great assistance to the Department of Health when

planning its nursing manpower to meet the country's health needs.

Constitution of the Council: In the Nursing Act No 50 of 1978 provision was made for the election as council members of five White nurses, three Black nurses, one Coloured nurse and one Indian nurse. In 1989 the Council petitioned the Department of Health to remove all references to racial groups in the Act. The motivation was that the Council is a professional body which does not distinguish between population groups insofar as training, registration or professional standards are concerned. This resulted in the Nursing Amendment Act of 1992, which made the Council a totally non-racial body.

The Nursing of Prisoners and Detainees: And before I come to this I just want to make a legal comment about constitution. We are aware that there are other concerns and it has to do with gender balances within the Council, it would seem it's female-dominated, if I may put it that way, it is a concern that is being looked at and I always say, they went to Beijing, maybe we should also go to Taipei.

The Nursing of Prisoners and Detainees: In 1988 the Council issued a policy document dealing with this issue, including political prisoners. The following extracts from the policy are highlighted:

“In her professional capacity the nurse maintains political neutrality. Any deviation from this is unethical because such impartiality provides the basis for mutual trust, respect and protection of the rights of the patient are indivisibly linked to the duties and responsibilities of the nurse towards such a patient”.

The following principal does apply:

It is the professional obligation of the nurse to provide life-saving care and alleviation of pain and suffering.

The patient has the right to the protection of his physical and mental health and whatever treatment and nursing are needed.

The nurse may not be involved in any relationship with a prisoner or detainee other than that required to evaluate, protect or improve his physical or mental health.

It is unethical for the nurse to participate in any procedure for restraining a prisoner or detainee unless medical grounds exist for such procedure in order to protect the physical or mental health of the prisoner or detainee or of these fellow prisoners or detainees.

It is unethical for the nurse to participate in any form of interrogation or torture of a prisoner or

detainee. In the case of torture it is unethical for the nurse to conceal knowledge thereof.

And finally,

Recommendations:

- a. Further Councils should ensure that no legislation or policy violates the rights and dignity of any nurse or any patient.
- b. The Council should promote the preservation of the image, dignity, integrity and values of the Nursing Profession.
- c. Openness and transparency, the right to be heard, accessibility and user-friendliness should be the fundamental premises to realise the role and functions of the Council based on exhibitions, vision and goals.
- d. Communication with the Profession and the community should be improved and intensified.
- e. The autonomy of the Council should be maintained and respected.
- f. In the event of victims of Council violations being identified, Council recommends that appropriate reparations be made for the benefit of such victims.

We also recommend that nurses should be encouraged to report human rights violations directly to Council.

And lastly,

With regard to any future collaboration platforms, if any are being mooted, we recommend that such platforms should be geared not to facilitate with regard to advisory resources to avoid stifling the all-important autonomy of the individual professions, more especially the Nursing Profession.

The Council would like to reiterate its apology to anyone who may have suffered unjustly as a result of former councils' actions and policies. Appreciation is also expressed to the Commission for the opportunity to make this submission. Thank you.

MS WILDSCHUT: Thank you very much. Maybe we should just move very quickly into the questions. I would like to ask the question relating the Nursing Council's relationship with other bodies internationally. What was the nature of the Council's relationship with such bodies, if any? And were there any representations from abroad or elsewhere in respect of Council's policies, racist policies, separate regis-

ters etc?

MR GERMISHUIZEN: Thank you Chairperson. The Council had a good working relationship with the Nursing Councils of the United Kingdom, the Republic of Ireland, Swaziland, Botswana, Lesotho, Namibia and Malawi. Those are all that we could find and we couldn't find any record that there had ever been objections from any of those Councils to Council policies there. The only correspondence seemed to be about matters of mutual interest such as nursing education and registration and so on.

MS WILDSCHUT: Were there any local objections that you know of, of nurses who were objecting to being on a separate register and does the perception being there that there are different standards for different races and so on?

MR GERMISHUIZEN: Chairperson, the only racial discrimination of which the Council was aware, now I'm speaking on behalf people who existed before my time there, was the keeping of the separate registers and rolls for the different population groups as prescribed in the Nursing Act of that era. Although we are not aware, as a Council of any specific complaints from the Profession, I am very convinced that there must have been many, but there was nothing that we could find in writing anywhere, but I'm sure that the Profession did object.

MS WILDSCHUT: So Mr Germishuizen, the only way in which objections are dealt within the Council is through formal writing to the Council so that if the Council were to be aware of any objections through Press, through conferences, through other means, it would not respond to those objections?

MS WILDSCHUT: I couldn't say they would not respond. All I can say is that we couldn't find any trace that there had been, either verbal or through the media or through letters, but I'm sure that there must have been objections raised. Maybe direct to Council members on a personal basis.

MS WILDSCHUT: I asked the question about the relationship within international organisations and your response is that the Council had a relationship with the International Standards Convention, am I correct?

MS WILDSCHUT: Yes the Council in fact was a founder member of a thing known as the International Conference on Nursing Regulatory Bodies. This was founded in 1993. Prior to that there didn't exist any forum for regulatory bodies to belong to. There was and still is an organisation known as the International Council of Nurses but that's an organisation for nursing associations and no regulatory bodies belong to

that.

MS WILDSCHUT: Yes, we have to understand the difference that the International Council of Nursing is for bodies of nursing associations and bodies that look after nursing issues rather than issues of registration or regulation and discipline, so we need to draw that distinction.

My question about the separate registers, what information did the Council gain from having a separate register, in other words, how did you use that data? What use was it to you to have separate registers?

MR GERMISHUIZEN: I can only speculate on that one, and my speculation I'm going to cancel out when I've said it, possibly so that the Council could provide statistics to the Department of Health on the numbers of nurses in the various population groups and having said that, it really is not necessary because up until about 1994 nurses were identified on the register which was by then long amalgamated. In fact from 1978 with the new Nursing Act there was only one register, but they were still identified according to population group, so I can't see what the point was at that stage, except that that was the policy of the government of the day.

MS WILDSCHUT: Nor could I. I couldn't ever work out why I always had a C in front of my registration number.

MR GERMISHUIZEN: Could I come in on that? Those letters, "W,C, V and I" have been removed. There is no way now of identifying the population group of any of the nurses, which in a way is creating some problems for the Department of Health if they're doing planning for nursing education for example. We can't give them statistics.

MS WILDSCHUT: The issue with relation to - there has been a lot of comment and criticism about the close relationship between the Nursing Council and the Nursing Association where senior members either were serving or had some dealings with the Council thus compromising impartiality of such members. How does the Council react to that? Is it unusual that nurses who are members of the Association are linked to Nursing Council and so on?

MR GERMISHUIZEN: The principle of members serving both on the Council and the Association did not create problems in itself. You must also remember that up until 1993 it was nurses were legally compelled to belong to the Association as well as to the Council and that in itself caused problems. But

criticism was expressed at the fact that somewhere in the early eighties the president of the Nursing Association was also the vice president of the Council and it was extremely difficult for this person to wear two hats, particularly on issues where the Council and the Association were on a collision course.

MS WILDSCHUT: Was there often a collision course because it seemed as though amongst nurses there seemed to be the perception that there was very close cooperation and very close collusion rather than the Council and the Association being on a collision course?

MR GERMISHUIZEN: Chairperson may I ask Professor Kotze to speak to this, she has more experience of that having been a member of SANA ...(intervention)

MS WILDSCHUT: Certainly.

PROF KOTZE: Chairperson I think one should look at the historical development of this. One needs to remember that the South African Nursing Council in this country was instituted through the work of the old South African Nursing Association, the South Association for Trained Nurses, SAATNA. So historically there was a close collaboration between the two bodies. As a matter of fact, when the Nursing Council was instituted in 1944 it did so with a £1 000 that the Nursing Association gave to it to start its work with, and over the years the leaders serving on the Nursing Association were almost naturally also members of the South African Nursing Council. This persisted for some 30 years. But over the past 10 years there's been a marked division that developed naturally between the two bodies, so that at the moment I don't think there's a single, and for the past five to six, seven years, there has not been a single member serving on the Association as well as on the Council.

So I think historically it's worked itself out and particularly with the factor of voluntary membership of the Nursing Association, that close relationship has been broken.

So yes, there were the effects and definitely there were conflicts and there was dissatisfaction amongst the professional members and the profession down at the ground because of this. But I think we've gone through that stage now.

MR GERMISHUIZEN: There was a marriage and now they're divorced.

PROF KOTZE: Yes there's been a definite divorce Chairperson.

MS WILDSCHUT: I raised the question particularly because it seems that it's important that nurses feel

that they have the Nursing Association supporting them in whatever activities they're about and that when it comes to issues of discipline and registration and so on, that that body is autonomous and not influenced by the decisions within the Association, and so I raised that because of that struggle. The Council has made an honest attempt at examining the past and we really do want to thank you for your presentation, but we also would like you to help us explore just one of the recommendations that you make.

Can you just elaborate a little bit on the Council's recommendation to preserve and promote the image of the Nursing Profession? What does that mean, and how can the Council be involved in doing that?

PROF KOTZE: Chairperson, the South African Interim Nursing Council has been working very hard on this particular matter because we were tremendously concerned at the poor image of the Nursing Council and the development of a poor image of the nursing profession in the country. We've done several things to combat that over the past two years.

First, with relation to the developing poor image of the nursing profession in the country, a launching of a campaign to stress nursing as a caring profession.

Also a campaign to make nurses more aware of the Council's rehabilitative approach in professional conduct matters so that the image of Council being a punitive body could change.

And then there's a concerted effort from the Council side to move towards becoming more involved in monitoring the standards of nursing practice in health institutions, because the Council realises that it's built up the image of an ivory tower over the years. Nurses are striking, they are dissatisfied with what's going on in the health services because of the poor conditions under which they work and the Council has always taken a stand against that and only regarded the interests of the patient in this regard.

Now Council realises that a lot of dissatisfaction among the members of the profession is there because of the poor conditions under which nurses work. For that reason there's proposed amendment of the Nursing Act to make it possible for Council to also inspect the conditions going on in health services in order to make recommendations and to help nurses with regard to that.

So that the emphasis will in future not only on the interests of the community but also on the interests of the nurse and the rights of the nurse to have the facilities and the conditions worthy of to give proper care to the community.

So there's a definite shift in emphasis in the approach of Council towards its own image and the image of the profession.

MS WILDSCHUT: I've asked the Chairperson for indulgence. He is not very happy with me about that but I just need to slip in one more question and that's related to standards that the Nursing Council may or may not be considering in relation to training for health and human rights, I'm not talking specifically about the nursing ethics training but specifically around health and human rights with specific emphasis on the treatment of detainees, treatment of prisoners and the treatment of people who have been severely ill treated in vulnerable situations.

MR MAUMELA: Ma'am the approach of the Interim Nursing Council to specifically the issue that you raise is currently under review. As you may be aware, there are different sub-committees within the Nursing Council, specifically the Laws Committee is busy reformulating with a view to make suggestions to amend some of these regulations in order to take on board all human rights considerations.

We are also tapping from the experiences of the past. We are also keeping our ear to the ground with regard to developments, even from the Constitutional Court, and also having a look at the interim and both the current constitution of the country so that we can be able to avoid visciating against those considerations.

MS WILDSCHUT: Thank you very much, I hand you back to the Chair.

MR GERMISHUIZEN: Chairperson might I just add a sentence to this, grant me your indulgence. Ms Radebe is the chairperson of the Transformation Committee which is a new committee formed by this Interim Council and one of its functions is to monitor how the other committees are transforming, and that would include the Education Committee. So the Transformation Committee is looking at what improvements are being brought into the training regulations to address issues such as has been raised. Thank you Sir.

CHAIRPERSON: Ms Mkhize has just one question.

MS MKHIZE: Just a quick one from me. I was looking at page three of your document where you referred to the formation of surrogate Nursing Councils in the Homelands. My question really moves beyond professional structures but around the human rights and patient care. In those settings we have

heard people coming before the Commission talking about how they died in the hands of nurses, mainly because the nurses were from the neighbourhood and they knew them very well. There were divisions, ideological differences and I was wondering whether you are aware of those problems in the Nursing Profession?

And if you are aware as to whether you have thought of any possible rehabilitation programmes which might assist those nurses who found themselves in the position where they will be influenced by their ideological persuasions in caring for people who appear before the health (...indistinct)?

MR MAUMELA: I will say there is a programme in place but it certainly becomes one of the issues that is being looked at. We are aware that the nurse, like any other health worker, has been used as a tool to perpetuate some of the atrocities. But with regard to having a programme in place, I think that is something that hasn't started as yet, most probably because one tends to feel that to a certain extent some of the activities within the Interim Nursing Council should not have the effect of preempting some of the bigger processes like we have the TRC and we have other people coming up with civil cases because of specific instances. But we realise even now, the need to change the mindset and I think it's going to be a process. It cannot be an overnight kind of a project and for that we also rely heavily on advices and guidance from other sources, even including yourselves.

MS RADEBE: Chairperson just on that point. We have heard today, from yesterday, that in the health system there was a sort of a relationship and a link in the way in which human violations were done on the patients. This link was not only basically facing the nurse, the psychologist or anybody or the doctor, it was also the question that some nurses became aware of these abuses but because of the linkage in the system between the professional organisations, councils, it was very difficult for the nurse to come forward with these abuses. Like we don't have a tangible project to say we have in the Council as part of a healing.

But another way that prevented nurses from reporting these violations was the mechanism, a system of management in the hospitals. That is why now in our recommendation, part of what we are doing as part of transformation is to have the Council accessible to all nurses from the ground and up to national so that the nurse herself is able to directly get in touch with the Council for whatever violations that could be there, without working through the mechanism of authorities within institutions like super-

intendents and nursing managers. The Council is now accessible to the nurse. There is communication that is on the ground. The Council has opened up issues with professional organisations like unions so that these organisations, together with the nurses and the Council, should be aware and if they are aware they know that there is a forum for them to report these violations.

So there is a concerted effort from the Council to be more open than before to work issues together, although in the true sense we haven't got on the ground an idea of a project for healing of the nurses themselves, but we have opened up a line to communicate directly with the Council. Thank you.

ADV POTGIETER: Chair thank you very much for being so indulgent this morning. Can I just ask, noting your reference to the approach of your predecessor to professional conduct issues as near militaristic and also noting your apology to those who may have suffered as a result of the actions taken by your predecessor, are you possibly engaged in a process of trying to identify cases where disciplinary action against nurses was unjust in nature, which would amount, as we understand it today as violation of human rights because it was political in nature, because it was racist? And are you taking steps to set those cases straight if those do exist?

And then secondly, are you aware of any prosecutions in terms of Section 49 where it was a criminal offence for a white nurse to be put under supervision of a nurse belonging to another race group?

MR GERMISHUIZEN: Chairperson could I start with the last question. We're not aware of any prosecutions having taken place but that does not mean to say there weren't any.

Your first question doesn't have an easy answer. The Council's Professional Conduct hearings have always been open to the public and in fact up until fairly recently invitations were even sent out to training schools and to hospitals. Nurses have always been allowed to have legal representation even though obviously many of them could not afford so. So that the actual hearings, the transcripts of the hearings, I don't think would indicate the Council acted against somebody on racial grounds. Again I'm not saying that individual members of the old disciplinary committees weren't biased in their own way but it 's certainly in the 15 years that I've been with the Council they never came through as such and if it had I wouldn't have stayed 15 years.

It's an interesting thought that you suggest that one does research into the past to see if nurses'

rights have been violated in any way and then to see in what way reparation can be made to them by the Council.

ADV POTGIETER: Should you not invite nurses who have complaints of that nature to come forward to you, for you to look into those and to see what you can do to set it straight?

MR GERMISHUIZEN: Yes we're now, the Interim Council also instituted a Newsletter for the first time which now goes out to - it will on basis of three times a year be posted to every individual nurse in the country. So we can certainly thank you for that suggestion.

ADV POTGIETER: Thank you very much.

MR GERMISHUIZEN: Thank you Chairperson.

CHAIRPERSON: Thank you ladies and gentlemen. Can I say, I seem not to have stuck to my words that I started off with which is that we're going to stick to time. I want to appeal to my fellow Commissioners on the panel that they restrict their questions or that they send questions to organisations so that they'll be able to answer in writing. So please, I'm going to actually stop further questions. I know Professor Simpson was not here earlier on, so I'm going to actually repeat what I said.

All the groupings that are now presenting will have only 15 minutes to present, so can I please ask Janet to come along. I'm afraid if you're thirsty you may as well start walking out now and get a glass of water. I'm not allowing a tea break, you'll have to wait until lunch. Thank you.

ABUSES IN RURAL PRACTICE

CHAIRPERSON: Janet welcome, will you please introduce yourself.

DR GIDDY: This submission is on behalf of myself and my husband Steve Reed and we are two doctors who worked at the Bethesda Hospital which is 250 bed rural hospital in Maputoland which is in North East KwaZulu Natal up near Swaziland and Mozambique.

CHAIRPERSON: Can I just stop you and can I ask, Denzil will you assist.

ADV POTGIETER: Only with pleasure Chair.

JANET GIDDY: (sworn states)

DR GIDDY: We worked for nine years in a rural hospital from 1986 to 1994. Steve objected to military service and was allocated to do six years of community service instead. Our work included a wide variety of clinical duties at the hospital, teaching of primary health care nurses, working as district surgeons and a responsibility for community work in a district of 70 000 people.

With regards to Human Rights abuses, we would take as a starting point that the right to basic health care is a fundamental human right. Anything which prevented access to basic health care could be construed as a human rights abuse and we will describe factors which undermined the provision of health care. We'll also describe situations in which health care available was abusive in some way.

The first point is the institutional neglect of rural homelands. The homelands of the apartheid era, largely situated in rural areas were dumping grounds of people. As doctors we dealt on a daily basis with the ill health and disease suffered by large numbers of mostly illiterate, poor and marginalised people. This is primarily the reason we've chosen to make this submission to the TRC in order to make known the plight of vast numbers of forgotten people who lived desperately on the edges of extreme poverty in harsh environments and battling with effects of diseases such as malaria, measles, bilharzia, TB, typhoid, aids. The marginalisation of rural people continues to this day and we believe that it is an urgent priority that this be redressed under the new dispensation.

When I was asked to make this oral submission, I was specifically told to just focus on rural private practice abuses and leave out all the other stuff and in fact I've specifically not done that because I feel like that, it's part of the general attitude that rural health is just a non-issue, it's peripheral, it's not a big priority. So that's why I'm speaking about my whole submission although I'll try to keep it to 15

minutes.

Inadequate funding of rural health services.

Rural health services have been chronically underfunded relative to equivalent urban facilities because they're conveniently out of sight and out of mind. They received less than half the budget allocations of urban hospitals of equivalent sizes.

The general shortage of health care workers.

A well functioning health team needs to be comprised of a whole range of professionals such as nurses, doctors, therapists, lab technicians, pharmacists and dentists. At no time while we worked at the Bethesda was there ever such a team. This is problematic for the following reasons:

In rural areas there are large numbers of people who are disabled and require physiotherapy and occupational therapy for example. It's an area where the mysterious Msileni(?) joint disease occurs.

We only had an occupational therapist for one year in 1993.

A dentist visited once a week for six months in the entire time. Otherwise the only dental care available was provided by the doctors who taught each other to do tooth extractions.

There was never a trained pharmacist employed at the hospital. The laboratory was always short-staffed which had serious implications for the work in an area where there were a large number of epidemic diseases such as malaria, TB, bilharzia, typhoid and others.

There was an ongoing shortage of nurses. This resulted in much of the work which should have been done by professional nurses being done by staff nurses who were compelled by the circumstances to function far beyond their scope of practice.

The South African Nursing Council would not have been pleased if they had known about these irregularities but we didn't think they particularly cared what happened.

The shortage of doctors.

One of the main reasons why rural communities did not have adequate basic health care is that there were not enough doctors working in rural areas. As we all know there's a severe maldistribution of doctors in South Africa. The vast majority live and work in urban areas. The reason for this are multifactorial.

However, we would highlight the following reasons as ones which could have been managed

differently.

Firstly incentives. The Department of Health provided inadequate incentives for South African doctors to work in rural areas. Some doctors employed by State health were given a territorial allowance which was an attempt to compensate them for working in these areas. Although it sounded reasonable one had to bear in mind the realities of living and working in a rural area. These doctors had no housing subsidy like colleagues in public sector jobs in urban places. There were many inconveniences and expenses associated with living in very remote rural areas including bad roads, having to travel far to do shopping, repairs or anything like that. Unreliable telephones or no telephones for months on end. Erratic electricity and water supplies. Schooling was problematic for those with children. There was no access to medical libraries for continuing medical education.

One could continue this list which serves to illustrate that life in a rural hospital was awkward or inconvenient for people. While a few adventurous doctors accepted the challenge of living in the bush and tried to live as positively and enterprisingly as they could, for most doctors these situational factors were serious disincentives to working in rural areas.

The Department of Health could have provided financial incentives to doctors to recruit them to rural areas. Many young doctors have loans to pay off and travel to other countries specifically to earn more money to pay their debts.

The Department of Health could also have thought of other creative alternatives, for example a paid sabbatical leave for any doctor who worked for a fixed period of time under a contract. There was such a system available to British doctors employed in a rather strange way, but no one else.

Rural medicine is uniquely stressful and the idea of paid long leave after a number of years of service would be a real encouragement to doctors to commit themselves for longer periods.

The KwaZulu Pledge.

There were to our knowledge no Zulu doctors working in rural hospitals in KwaZulu between 1986 and 1994. The University of Natal have been graduating Zulu doctors for about 40 years, so how did the situation come about? The reasons are complex but one important one I've singled out was the KwaZulu Pledge. This is a law requiring all KwaZulu public servants to sign an oath of allegiance to the KwaZulu government and its leaders. If a person refused to sign the pledge they could not be employed as

a public servant in KwaZulu. We ourselves were not required to sign it as we are employed in State health posts. This pledge deters Zulu doctors from working in rural areas.

The lack of academic support for rural medicine.

Doctors need training, professional support in the field of ongoing continuing medical education in order to be motivated to do a good job and to provide a good quality of service. The University of Natal showed very little interest in rural medicine. While there may have been political and situational reasons for failing to provide academic support for rural health were they truly adequate excuses for neglecting to support the doctors and health service that attempted to provide health care for a few million under-served poor and marginalised rural South Africans? We do not believe the excuses were adequate.

It is our firm recommendation that specific attention and resources be given to rural health and rural medicine by the country's medical academic institutions, a kind of affirmative action towards rural areas without which the situation is likely to remain unchanged in the future.

Very few South African doctors and the difficulty of registering foreign doctors.

There are very few South African doctors who are willing to work in rural hospitals. Many were leaving the country for personal as well as political reasons. These included the problem of conscription for White male doctors, the general level of violence and unrest in the country and perceived unsatisfactory working conditions.

In contrast to this was the situation of doctors from other countries wanting to work in South Africa, often specifically in rural areas. It is not an exaggeration to say that in the majority of rural hospitals, foreign doctors were the life-blood of the service. Without them there would have been no service. The problem was that the procedure for registration was difficult and got worse from the mid-1980's. We were very frustrated by corresponding with interested doctors from countries with a good standard of medical training to see them lose interest because of the problem of registering with the South African Medical and Dental Council. The burden of an understaffed health service which could have been lightened continued. Ultimately he suffered with the disadvantaged rural communities.

The consequence of lack of doctors.

If doctors left and there was no one to replace them it created enormous stress and overwork for those who remained. No one wanted to go and work in a hospital that was badly staffed because they

knew it would be very stressful, so more left and a vicious cycle developed. Some hospitals were down to one or two doctors for two or three hundred bed hospitals and there were some hospitals that had no doctors for a few years.

The next part looks at doctors who do not respect the human rights of their patients. This is what the TRC apparently most wanted to hear about. There were a number of GP's in the area who provided curative health care on a private basis. On a few occasions I did locums for them and was thus able to experience aspects of their practice which undermined the dignity of the people who were unethical in some way.

Firstly separate facilities.

Black patients were treated differently to White patients. Doctors' surgeries were divided up and had separate waiting areas as well as consulting areas. Whites had a waiting room which was comfortable while the Black patients waiting room was uncomfortable and inadequate. It might have just been a verandah or just sitting outside on hard benches or on the ground.

The consulting areas were also different. The White patients were seen in a room where there is privacy, a desk where the doctor sat, an examination couch and curtains around the bed for the patient to undress with dignity.

The Black patients were examined in a room which had been divided up with partitions to create three or four kinds of stalls which is a narrow space which scarcely fit an examination couch. The doctor stood and hurried from one stall to the other and they lined the patients up. There was no privacy as the partitions did not prevent patients from hearing what the doctors said to others. There was no linen on the couches. It was very uncomfortable. The situation was undignified and created a feeling of a depersonalised production line.

The abuse of the jova(?)

Black patients were treated differently to White patients. They paid a standard fee for which they got a consultation and medication as part of a package deal. Medication had to include an injection, the Zulu word for which is the jova as well as two or three different kinds of pills or medication in syrup form. When doing a locum I was told in no uncertain terms that this practice was non-negotiable. Every patient must have a jova. When I asked what to give a baby with diarrhoea, which is a common primary health

care problem which requires a detailed enquiry into feeding practices, use of enemas and then advice about oral rehydration but no medication. The doctor said, oh just give them anything, penicillin, streptomycin, gentomycin, sterile water, vitamin E, anything you like but just make sure they get the jova.

The practice was defended on the grounds that the patients demanded it and were not satisfied with the consultation if they did not get it as well as a few other pills. Clearly the GP's felt they would lose patients if they did not continue this well established practice. For medical and ethical reasons this is a very problematic thing. I won't go into it now but if people want to know at questions...

I was told stories by nurses about GP's re-using needles until they were blunt. This was something they had observed while attending GP's as patients. This practice is purely unethical and dangerous and spreads infections such as hepatitis B and HIV.

Failure to provide primary health care.

GP's are in an excellent position to provide primary health care, the minimum being to give routine immunisation to children. They do not do it. This results many missed opportunities. I would add that I know that none of these circumstances are any different now to the period under discussion.

The third point was police violence.

We were expected to do medical examinations to determine if minors were medically fit to be whipped by the police. This was degrading and humiliating for all concerned. We saw patients who had been assaulted or tortured by the police. I won't talk about this because people have talked about that a lot.

Disability is something I want to talk about because I feel like nothing has been said about it in these health hearings.

Disabled people have very difficult lives in any situation but particularly so in rural areas. Wheelchairs cannot move on soft sand and life is often intolerable for people with serious disabilities. I'd like to tell you just about one patient of ours, a Mr Frans Pimbi. He became quadriplegic after an accident in 1979. He had no movement in his legs and only a little in his arms. He was totally dependent on his mother for everything and he was confined to a wheelchair. They lived in a home comprised of sticks and mud huts about 10km from the hospital and he received a disability grant of R242 every second month. He was subject to terrible urinary infections and bed sores which were difficult to treat because of the scarcity of clean water and the distance from the hospital.

In other situations Frans could have expected to access resources and assistance to cope with his condition but because he was Black and because he lived in a rural area, he suffered far more than others with similar disabilities and he died far sooner.

I present Frans's story as an example because his life and subsequent death of TB in 1990 was an expression of the abominable effects of the whole system on an individual. That he lived with such dignity and inner strength, despite the cruelty of his situation was a source of great inspiration to us and testimony to the power of his faith in God.

As District Surgeons we were obliged to assess applicants for disability grants, a system that was fraught with difficulties. Many who were clearly eligible, or had serious disability, had endless bureaucratic problems. The system was very inefficient, bureaucratic, waste of the time of all concerned and in many, many cases corrupt. People whose lives were filled with physical suffering were given very little real support.

The last point is TB repatriation from the mines.

In the course of our work we frequently came across TB sufferers who have laid off work at the mines because of their illness despite an official policy to the contrary. They were paid out a lump sum and discarded by the employment agency TEBA because they were unfit to work and ended up in our TB wards with their lives barely intact.

In conclusion, we have highlighted a number of situations in which we felt that the Medical Profession and those responsible for the provision of health services abused the human rights of rural communities and individuals through the neglect of their duties towards them. We know that people died prematurely and suffered immeasurably in obscure corners of rural South Africa as a result of these sins of omission. Their suffering was no less significant for its hidden and undramatic nature.

It is our hope that by sharing these experiences and raising the issues that the health of rural people and communities in this country would be given the attention it deserves in the New South Africa. In many ways it is an indicator of the extent to which the new government succeeds in its task.

CHAIRPERSON: Janet thank you very much. You've packed in everything in the 15 minutes. You've also raised your concern that the TRC asked you to concentrate on one aspect. You've done that admirably. I've said already that we're not going to be asking questions. If people wish to send you questions

we'll send those to you. I hope you will, because many of the issues that you raise need to be continually discussed and taken up, certainly in the workshop this afternoon. I hope you'll be staying for that workshop.

DR GIDDY: I can't stay for the whole time.

CHAIRPERSON: Thank you.

Maybe as I sort of prevented stops, I've prevented people from going to tea, if you'd like to stand for three minutes just to stretch your legs while Professor Simpson comes to the table.

SHORT ADJOURNMENT

PSYCHOLOGICAL ABUSE IN DETENTION

CHAIRPERSON: Professor Simpson are you ready. Can I just say that if people want copies of the submissions they can make a copy at a Quick Copy which is down stairs, Shop 6, 101 St George's Centre, and they have all the submissions there.

Professor Simpson before I hand you over to Mr Denzil Potgieter will you just introduce yourself.

PROF SIMPSON: Thank you Fazel. My name is Professor Michael Andrew Simpson, I am a physician, psychiatrist and human rights activist. I was in exile from South Africa from 1961 until 1984 and then returned and worked on a series of major human rights court cases from 1984-85 to date. I returned having worked as a professor and senior academic in Britain, America and Canada and with special emphasis in my research on human rights and on the effects of trauma on individuals and communities.

CHAIRPERSON: Thank you. Denzil.

ADV POTGIETER: Thank you very much Fazel. Professor I'm just going to ask you to take the oath before you present your testimony. Thank you.

MICHAEL ANDREW SIMPSON: (sworn states)

CHAIRPERSON: Professor your presentation will deal with psychological abuse in detention. You have in fact furnished the Commission with a very very full written submission and you have arranged to let us have access to a lot of other material which is relevant, which we will use together with your submission for the work that we will be doing but for purposes of your presentation here, you will simply just be highlighting the main sections of your full submission that you have made to us in writing. Over to you.

PROF SIMPSON: Thank you Sir. I've spent the last six months abbreviating thousands of cases with evidence into hundreds, into dozens and the 60-minute presentation has been cut down - I am pleased I've spoken before it's been cut down to ten minutes.

I was struck by the similarity between my experiences and those of David Klatzow yesterday. Having been subjected to cross-examination and often very, very cross-examination as an expert witness for up to three and a half weeks in human rights cases, I know what he meant about the appearance of confabulated and fake expert evidence which never ever, ever received critical attention of the courts. I think what we often experienced were not simply miscarriages of justice, they were full legal abortions of justice.

I would also like to support what Francis Ames said yesterday about how some of us were harassed and discredited for speaking the truth. We need and deserve and look to you ladies and gentlemen for proper and official rehabilitation.

The extent to which racism and the disregard of the human rights dominated South African health care is hard to believe, even to those of us who lived through it and struggled against it. As an illustrative example, when I was the medical director of the Highway Hospice in Durban, which I think was the first non-racial hospice in South Africa based in what was classified as a White area though servicing all areas we could reach. We insisted on providing non-discriminatory health care to anyone who qualified by the simple criterion as being a dying patient. And one day I received a telephone call from a senior government health official, saying,

“Professors we have received complaints about your Hospice. It is in a White area and they tell me that you are allowing Black people to live there, and this will have to stop”.

Swallowing my anger and thinking quickly I said to him,

“Sir, you are seriously mistaken, this is a hospice and palliative care programme and devoted to preserving the dignity of our patients and reducing their suffering. I’m allowing Black people to die in this hospice and can you please tell me which law specifies where they are allowed to die?”

There was a long silence and much rustling of paper and he finally admitted very grumpily that he could not think of any regulation that specifically forbade that and we continued caring for all who needed our help, and we didn’t hear from him again.

I think one reason I quote that sort of example is I think it is under-appreciated how much might have been achieved, perhaps in a succession of similar small victories, had anybody bothered to try to say “no” more often than most of our colleagues ever did.

It had been noted in all significant other historical examples of oppression, the indifference of the bystanders is critical for the success of the aggressors. It is deeply unwholesome that in the South African situation the bystanders continue in many cases and we saw some illustrations yesterday afternoon to deny, develop amnesia and ignore the essential role they played in that past process. This is a political ointment but one that the health care sector should not accept. It’s not anyone’s task to comfort the afflicted, it is sometimes necessary for us to afflict the comfortable.

There has been far too little genuine debate about the nature of social healing and what surely promotes it. Truth is one essential component of the needed social antiseptic which could cleanse the social fabric of the systematised habits of disregards for human rights, but it needs to be an examined truth, it needs to be considered, thought about, debated and digested and metabolised by individuals and by society. Failure to comprehend recent suffering is too often, in the studies I have made received, the seed of future suffering.

Soon after my return to South Africa I began to be consulted about the problems of political violence and of political detainees. Perhaps our first major case was the case of the detainee Surish Surnee(?) in 1985, in which we succeeded in gaining his release, as I think was entirely appropriate, on health grounds, but from that date on I and those of my colleagues who assisted in that case received

consistent severe harassment, both within the university and outside it, including death threats and death attempts. Some of us were dissuaded from such work by these experiences and some of us perhaps being more congenitally stubborn continued. Cases I worked on include State v Tsele and Others in Newcastle and Utrecht which occupied much of my time over three years. The State v Tuka and Others in the last of the major Delmas trials, the matter of my colleague who has joined us today and yesterday, Ebrahim Masinya, an ANC official who was kidnapped from Swaziland and very severely treated in captivity, and the lengthy Potgietersrust inquest into the death of Donald Madisha from 1990 on in which incontrovertible evidence of gross irregularities and improprieties in this very highly suspicious death of a detainee, perhaps one of the last of the detainees to die in detention even after 1990, was so carefully and skilfully ignored by a magistrate sitting with a professor of forensic medicine as an assessor.

There are many examples but I have, at your request, winnowed those down to a few that specifically most clearly illustrate the problems, but we do appeal, and I've discussed this with many of my colleagues from more northerly regions, appeal to you very distinctly to enable at least a further hearing at which more of these examples of which there are so many, can be examined properly because the process you have begun is one that cannot be curtailed, and if it is, the fact that you have done it, may be used by many others as an excuse not to take it further and the process has to be taken further.

We need to recognise the roles of those that were played by, not only by those who actively assisted in the abuses that occurred, but also the essential role played by those who so deliberately and skilfully ignored what was going on.

Bystanders in the health sector were not as they claimed being neutral in a conflict with regard to item issues involving torture and repression. Doing nothing or behaving as if nothing untoward was happening is not neutral. It is highly effective and often essential assistance to the primary perpetrators and renders one a secondary perpetrator. No doctor expects to be neutral in dealing with cancer or aids and we should not consider our task or our role any different in dealing with torture and repression which are merely cancers and infections of freedom.

When doctors, as so many whom I am naming to the Commission in my more detailed submissions, when doctors and other experts were actively involved in helping to disguise the evidence of abuses that occurred, they were actively assisting in the survival of evil as much as if they had allied themselves

with the virus.

It is also important to realise that none of the major institutions, including the Medical and Dental Council, ever took action including cases I didn't mention in their submission yesterday, as in the Soni case where one of the psychiatrists who had examined him announced in his affidavit, both that he had advised this man to end the suffering which was essentially self-imposed because all he needed to do was to tell the Security Police what they wanted, and of course he would then be released. Who actually, I am told by the detainee himself, was advised by the psychiatrist of the details of the witness protection programme that he might have access to then and who, in his affidavit stated that he would advise the interrogators to finish their work by whatever means they saw fit as soon as possible. We, myself and other colleagues at the University of Natal at that time reported this case with documentary evidence to the Medical and Dental Council. They sat on it for over 18 months. They came up with ridiculous delays like writing back to us to ask if this was actually a complaint and we couldn't imagine what else it might have seemed like to anybody, and eventually decided that there was absolutely no case to take beyond even the preliminary investigation phase.

Let me give some other brief examples. A doctor from a department of psychiatry at a major university took part in the treatment of a political detainee suffering from PTSD following his interrogation in solitary confinement, a patient who had been referred to him by the prison doctors and by a colleague at another medical school, without revealing his intentions to his patient and without obtaining the patient's consent, the doctor then worked very closely with the State prosecutor advising him, even in court, whispering into his ear during the prosecution of his patient in a case in which the State was challenging the diagnosis and the necessary management of that patient, yet without himself testifying, which enabled him to do this without having to stand cross-examination about his extraordinary contact.

Another psychiatrist, who worked very extensively with the Security Police, and there were some who boasted of their earnings, and I suggest it would be very profitable and fruitful for the Commission to enquire with the Department of Justice and other relevant bodies about the amounts that were paid to certain individuals, I'd be very interested to know on the principle of Faust's experience what the cost of a doctor's soul is. I'd like you to find out how much some of these people were paid and for how long. If what they boasted to us are true, it is astonishing.

Another psychiatrist who worked very extensively with the Security Police provided opposing evidence uniquely and consistently in case after case where there was clear evidence of damage to and abuse of political detainees. In various trials he asserted in his testimony to a number of very highly eccentric and idiosyncratic opinions entirely unrelated to international expert and professional consensus, but all characterised by absolutely perfect convenience to the needs of the State's defence of the Security Forces against the complaints of detainees and prisoners.

Amongst his opinions he testified under oath, for example, that at interrogation conducted with the subject kept standing for up to 10 to 14 hours at a stretch without rest, would not be highly stressful, and he stood there lounging against the witness box and remarked impertinently that he had been standing for some time answering the questions of the defence counsel and he felt fine.

He testified that PTSD can never be diagnosed without absolute external, independent, irrefutable and objective proof of the facts and nature of the trauma, which would not only invalidate almost every example of the diagnoses certainly made on earth in the last 20 or so years since the diagnosis exist, but would mean that in the case as was needed in this case of political detainees, in the case of rape victims and so on, the diagnosis could never be made without the active approval, consent and assistance of the rapist and the torturer.

He testified that it was impossible for the defence psychiatrist, in this case myself, to have conceivably diagnosed PTSD after examining a patient for a mere total of 12 hours and without a 30 days period of in-hospital investigation and observation including a host of investigations, everyone of which have been shown by international research to be irrelevant in making that diagnosis.

On the other hand he was able with absolute confidence, absoluut beslis to testify that he could authoritatively diagnose that this man suffered from absolutely no psychiatric condition whatsoever, actually one of the more difficult diagnoses to make reliably, on the basis of not having examined the man, having deliberately avoided even hearing the man testify in court, but having watched from across the court room, the man's face while the man listened to my testimony. On that basis, he of course, without the 30 days observation, not even the 12 hours, could diagnose that there was nothing wrong with the man.

There's much evidence that this man, for example, among others worked closely together with the Security Police. On one occasion in a break in the court case, I flew from Natal to the Cape to talk to a

group of doctors and on the first day back in court this witness, who had a habit of having tea with the magistrate in the absence of the members of the defence team, strolled up to me and said, well what was the weather like in the Cape over the weekend, in order to let me know that I was under surveillance. He had full access to the results of that surveillance.

In the case of another political prisoner kidnapped in another country and brought to South Africa under duress, the man developed very severe psychiatric symptoms after interrogation and torture. A prison doctor wisely decided to arrange to transfer his patient to the psychiatric department of the local university hospital for observation and expert treatment, but his clinical decision, and we can prove this from affidavits and from court transcripts, was intercepted and countermanded by a more senior district surgeon who had never examined the patient and later showed spectacularly little knowledge of the man, but admitted under oath that he had discussed the case with a senior security police official and decided, and I quote,

“...in collaboration with this police official to instead transfer the ill man not to a university hospital for observation and treatment but to another solitary confinement cell, simply in a different city where he would have access to a forensic psychiatric specialist who worked exclusively with the Security Police in almost every case, who no longer treated patients but simply produced reports that were used in court cases and as in this case was used to oppose an application for the release of the patient”.

There's another similar doctor whose diagnosis, so far as I can discover, in every single case of every detainee and torture victim he saw, was an adjustment disorder. The most trivial diagnosis he could give in such circumstances, when he was not for some reason able to diagnose nothing, his preferred diagnosis.

In this case this psychiatric forensic specialist saw the man who had been tortured and who described having been kidnapped and having been tortured, impatiently made a note in his handwritten notes of the consultation, that the patient he said rather waspishly was giving, “many irrelevant details”.

A professor of forensic medicine and author of a standard text book in the topic was appointed as the assessor in an inquest into the sudden and deeply suspicious death of a political prisoner. Amongst the evidence given to the court which he never challenged or questioned in any way and which he allowed the

magistrate to accept without question, and to reach a verdict in which no one was found in any way responsible for the death, include such fascinating facts as the fact the patient had received a very substantial intravenous injection of valium some 12 hours before he was found dead of asphyxia, yet no trace of any drug had been found in his blood at death and valium should have been found detectable for weeks afterwards.

The police surgeon had claimed to have ascertained on examining the dead man that he had been dead for exactly 20 minutes, a figure that was actually very important in order to exonerate certain of the police who were believed by the family to be responsible for the death.

Now I keep as good a touch as I can with modern developments in forensic science and I know that there is no way known to human science to determine the time since death as accurately as to within 20 minutes, particularly within the first hour or so of death. We speculated in the defence team as to what miraculous scientific tool he may have used to try to achieve this and eventually he admitted under cross-examination that the brilliant tactic he had used was to lay his hand against the forehead of the dead man and guess. But this fact, this testimony, this expert testimony was accepted without challenge by the professor of forensic medicine and by the court.

In the same case we had evidence from a police surgeon, a very old man who testified that he was responsible for the "care" of all the security detainees within a substantial area in the Northern Provinces. He had noted in the medical records that were kept in the Section 29 File and had provided in his affidavit a statement that this detainee had never had any complaints and had received no treatment. When in an enquiry, because his handwriting was even more disgusting than mine and completely illegible, he suddenly produced to our amazement, a duplicate set of notes, the clinical equivalent of double bookkeeping for the same patient but which he kept in his personal and private files, which revealed that the man had had many health complaints, had been treated by him on a number of occasions, and he had diagnosed and probably genuine and some rather strange diagnoses such as chronic appendicitis in the same patient. A local district surgeon called to the man on the night before his death found him acutely disturbed and shouting that "they" were going to kill him and his family. Something which we know well and you on the Commission know especially well, often did happen, at least not necessarily an indication of paranoia.

According to his sworn statement he diagnosed immediately schizophrenia, an impossible diag-

nosis to make competently under those circumstances and treated the man with intravenous valium which is not even the treatment for schizophrenia.

After reading my preliminary...(intervention).

CHAIRPERSON: Professor sorry, I am going to have to ask you to wind up in two minutes.

PROF SIMPSON: I would be sad if the Commission was as adept at silencing me as the State has proved to be earlier. I must finish that example for example, otherwise what I've already said would make no sense.

After reading my preliminary expert report to this effect, and after meeting with a specialist psychiatrist called by the State to assist, a former head of psychiatry at 1 Military Hospital, he began his oral testimony by asserting that despite what he had said in his affidavit made the day after death, he actually hadn't diagnosed schizophrenia as he had said but had actually diagnosed a brief reactive psychosis, a very highly convenient fiction but a very rare diagnosis and not applicable in that case. The same doctor testified that he had conducted a comprehensive and competent full physical examination of the patient in a small and dark cell in which there were three policemen who failed somehow to see this occur and with the patient remaining standing and fully clothed throughout the procedure.

Leaving out many other examples let me move to a close, but I repeat and reiterate my call that we cannot abbreviate the professional discussion of these issues, and there is, as far as I can see no other forum in which this will be allowed or enabled to occur.

There will be those who complain that our efforts in this section of the TRC's work may damage the national and international reputation of the medical and other health science professions in South Africa and this complaint is of course mischievously false. The reputation of these professions was massively damaged by the active misconduct of relatively few professionals and the passive acquiescence of a far larger proportion.

Facing what actually happened and learning from these experiences and striving to prevent their recurrence, and ensuring appropriate professional discipline for those whose conduct was professionally unacceptable is the only way in which our professions can deserve to regain a good reputation.

There is no statute of limitation on unprofessional and ethical conduct and no one may be given amnesty for such conduct.

If we wish to become genuinely and comprehensively healing professions again, we owe it to the victims, and I occupy the uncomfortable position of being expert and victim, to continue and complete this process of examination, comprehension, reparation and prevention. These are necessary parts of the healing process and healing does not occur just because it is declared to be desirable.

I'd like to close with a quote from Albert Kamu(?) who helped towards defining our admission, using the metaphor of a pestilence, a plague to reflect the encounter with oppression, and he wrote eloquently about how a doctor felt compelled to join in a struggle against the plague. The doctor, he wrote did so,

“So that he should not be one of those who hold their piece but should bear witness in favour of these plague-stricken people, so that some memorial of the injustice and outrage done to them might endure, and to state quite simply that what we had learned in the time of that pestilence, that there are more things to admire in men than to despise. He knew that the fate he had to tell could not be one of the final victory, if could only be the record of what had had to be done and what assuredly would have to be done again by all who, while unable to be saints, but refusing to bow down to pestilence, still strive their utmost to be healers.”

Preparing for this testimony I find has stirred up, to a degree to a degree I didn't expect, my own symptoms, but I think, I pray that like the victims I work with, that just as we try every night as I am cross-examined in my sleep, not to allow the wicked people to triumph in the land of our dreams, as they did triumph in the land of our birth.

Thank you.

ADV POTGIETER: Thank you very much Professor. Thank you for that presentation. We do have all of the wealth of information that is contained in your full submission before us, so it's a pity that there are always these time constraints on us in the public work that we do, but we do have that submission, it will form the basis of a lot of our work and you have kindly indicated that we would be free to be in touch with you to get access to a lot of other records that you do have. We want to thank you very, very much.

DR W ORR: Professor Simpson I want to add my word of thanks and to say that far from attempting to silence you, what we are trying to do here is give as many people as possible a voice and we perhaps have

been over ambitious, but I will most certainly ensure that arrangements are made for follow up interviews with you and for access to your expertise and your information. This is the beginning of a process, it's not the end. You have revealed some very important information to us and we know you have more and we will most definitely ensure that that is heard and included in our report. Thank you very much.

PROF SIMPSON: Thank you I look forward to our continuing to work together.

CHAIRPERSON: Thank you Professor Simpson.

PSYSSA SUBMISSION

CHAIRPERSON: Can I please call Lionel Nicholas and Don Foster.

PROF NICHOLAS: Don was here earlier but he seems to have disappeared, I'll just have to go on without him.

CHAIRPERSON: Thank you Lionel will you just introduce yourself before I hand over to Hlengiwe Mkhize.

PROF NICHOLAS: I'm Lionel John Nicholas, I'm a professor of psychology at the University of the Western Cape Counselling Centre.

LIONEL JOHN NICHOLAS: (sworn states)

MS MKHIZE: Prof Nicholas I would like you to take us through your presentation and I will ask you a few questions which you might have to give us a written report afterwards, but for the record I would like to ask you a few questions afterwards.

PROF NICHOLAS: I'll keep my presentation brief so that I may be able to respond more fully to questions that may be of more interest.

This is the submission of the Psychological Society of South Africa and deals with professional psychology associations responsibility regarding human rights. I'll give a brief history as I've outlined in

the submission and then go on to the testimony.

The first Psychology Association was established in 1948 with a membership of 34. In 1962 a new association was established, the Psychological Institute of the Republic of South and it was established because the existing body had eventually, after much to-ing and fro-ing had decided to admit Black members to the society. This new Society was exclusively for Whites and got adulatory responses from people in government and other White institutions in the country.

Psychology, from its earliest times, has been a very active force within the racism debate and for example three professors of psychology felt so strongly about keeping Blacks out of the first organisation that they arranged a meeting with the Prime Minister to persuade him to extend the powers of the Group Areas Act so that meetings where Blacks and Whites would confer together would be banned. One of the psychologists le Grange, which included van der Merwe and du Toit from Stellenbosch University became the first president of PsySSA.

The two organisations that served professional psychology merged in 1983 to form the Psychological Association of South Africa and I would like this gathering to note that the racist organisation, PsySAA, did not dissolve and rejoin the other one, but it was - both organisations dissolved as if both had equal access to this joining.

PsySAA dissolved in 1994 to form the current Association mainly because it was felt that this organisation still was very much wedded to the more conservative interests of psychology and that the previous organisation PsySSA in fact played the major role in this new organisation. There were also protests from different groupings of psychologists against the existence of this organisation.

Some other organisations that served psychology were the Student Counselling Organisation in South Africa, SSCSA, established in 1978 at a meeting of delegates from 15 universities and this organisation continues to represent counsellors at tertiary educational institutions in South Africa.

This organisation really did hardly anything to promote human rights or to look at racism or issues of oppression at universities or other tertiary institutions, and a survey of the papers of their conferences between 1978 and 1985 found that not one paper challenged the status quo, analysed the influence of apartheid on counselling or dealt with racism. This organisation in fact had a very cosy relationship with the South African Defence Force at that time, giving donations and promoting visits to the boys on the

border.

A separate organisation, OASSSA, who will present something later on so I won't talk much about them was established in 1985, including psychologists and other social service workers and endeavoured to provide services to communities and individuals who would not usually have access to such services.

In 1988(?) a grouping of psychologists were formed called the Psychology and Apartheid Committee and this grouping specifically focused on issues of oppression and Black empowerment within psychology, because up to that time very few Blacks qualified as psychologists due to the active work by White psychologists to keep Blacks out of this training.

I'll now go on to look at what kind of contribution to a human rights culture psychology made.

It is my opinion that psychology did little to advance human rights in South Africa, and in fact those who did try to advance such human rights were usually subject to censure from main stream psychology. The (...indistinct) of human rights was always considered to be bringing politics into psychology, it was something to be avoided at all costs. What was curious about this position was that rightwing activism, active political work in psychology was not considered as politicising psychology.

I'd like to use a few examples to illustrate that psychology has always been involved with politics. As early as the late 1920's three psychologists, E G Malherbe, R W Wilcox and H F Verwoerd advocated job reservation and legislation to inflict severe penalties on sexual intercourse between the races after concluding their research on the poor White problem, psychologists like M L Fick and J van Rensburg, among others, who propagated ideas of Black intellectual inferiority Psychology's general neglect of the issues of oppression, racism and socio-political problems in its teaching, training and research.

I will also read a quote from the current president of PsySSA who had the following experiences as a health psychologist and health practitioner while a political prisoner and an aspirant psychologist. This is his quote that he faxed to me.

“Health practitioners in the service of the State, in my experience, were generally under the thumb of the security apparatus in the bad old days. Even when it came to practitioners in hospitals like Groote Schuur, they tended to adopt an attitude that indicated their subservience to the requirements of the Security Police or the Prison Administration. Indeed

many of them, including specialists, used by the Prison Department would rather gather their information from warders or jailers than myself. I often wondered who the actual patient was. Like the experience of being a Black servant in a racist master's household, I, the patient, became invisible. With psychologists from General Roux to those he appointed to Robben Island, they were clearly uninterested in the issues presented by the inmates. Theirs was to act as an information gathering conduit for their bosses. The psychologist who visited me and my fellow inmates from the PsySSA BPC Trail at Victor Verster Prison one month before my release in November '82 rarely interrogated us, or at least tried to do so. His role was to ferret out exactly what we would do on our release. He actually told me that if I became a psychologist I would be dangerous to the State because the insights I could bring to political organisations that I would be able to decide who would be an asset and who a liability to the struggle while sifting out agents.

This theme followed me to Wits University selection for the MA in clinical psychology where I was subjected to interviews, even by progressive psychologists, about whether I could be let loose on the public. Sterkfontein would not have me as an intern because Head Office decided that I should not put my foot into a State facility. Tara Hospital had to then decide if I was suitable for them. At UCT they also felt eventually that we are taking a chance on you.

Some of these attitudes still prevail when selecting Black candidates despite White protestations to the contrary playing gate-keeper to the Profession, a situation of the problem perpetuating itself”.

This is a statement by Dr Saths-Cooper.

Other experiences that also bear this out are the experience of Breyten Beytenbach as detailed in his book the Confession of an Albino Terrorist. He give his contact as follows:

“The prison psychologist...”

or the way he called them, “psychologist”.

He describes his meeting with what he called,

“...the big boss of the prison shrinks. He was short fat balding fanatic wearing glasses.

He was the head of the special wing for psychopathic prisoners in Zonderwater Prison. I talked to people who have been through there they had no privileges at all.”

He goes on to account a conversation with a Dr Roux which Dr Roux later denied had taken place. Dr Roux was the head of the Prison Service and was a psychologist and obviously determined a lot of the psychological standards within prisons and Breytenbach recounts that during one of his conversations with Dr Roux the following took place:

“He gave me a spine-chilling but quite coherent exposure of his own political beliefs. I should not say beliefs, maybe this was more in the way of reactions. He was curiously needing to justify and defend his position, although I had not said a word. It came down to the old line of we are living in a dramatic period of exceptional importance, having to face in combat extraordinary challenges. We cannot afford to be manacled by a concept such as democracy or even decency, we, meaning them, need to be strong to go all out in a total answer to the total onslaught concept. Our fate is fatal, rather suicide in the desert than anarchy in apocalypse.”

He gives another quote in his book of the resident psychologist of Pretoria Central Prison, Colonel van Alwaard(?)

“He had me go through the gamut of outdated tests, the rash of blots and blobs, squiggles and various IQ examinations. Naturally I was never informed about any of his deductions. I was the guinea pig. These perverted practitioners of the spurious science of psychology do not have as their first priority to help the prisoner who may need it, they are the lackeys of the system. Their task very clearly is to be the psychological component of the general strategy of unbalancing and disorientating the political prisoner.”

Even in the SADF there were projects linked with psychology that have been presented to a secret meeting of this body.

This brings to the end the formal submission. Professor Foster was supposed to continue at this point but I don't know whether he is here yet or if he's not arrived. We hope to include a great deal more detail in our final report and we also await other reports from different groupings that we think might elucidate matters in regard to the Human Rights culture. Thank you.

CHAIRPERSON: Thank you.

MS MKHIZE: Thank you Professor Nicholas. I will ask you a few questions as you have indicated that you will like to engage in a debate with the Commission. I know it's difficult for me to be asking you these questions knowing your struggles especially within your project Psychology and Apartheid, but the first question which I would like to ask you is, can you describe the underlying ethos of the policy of the Psychological Association of South Africa, especially at its founding in 1948, SAPA?

PROF NICHOLAS: The first one. There was no explicit reference made to race in the founding of the first organisation because it seems that it was just assumed that Whites should be the only people who would qualify as psychologists. This did, however, not stop them from not admitting Blacks who applied to this organisation even though their constitution didn't prevent this. They then engaged in a debate for about two to three years. I had a conversation with a woman, Ms Naidoo, who was the first one to apply and she experienced this as extremely humiliating and you would also think about any Black person who would then be thinking of trying to study this field, what this kind of debate would have contributed to their desire to even continue to study as psychologists.

MS MKHIZE: Well I was asking you these questions because while we were preparing for these hearings I received a statement from my colleague next to me, Dr Ramashala, who said she was refused admission as a psychologist within this professional organisation. So I asked her to write that in detail. Basically she was saying the university which had trained her, Wits, didn't really make an issue out of that and ultimately she left the country.

My second question for you is that I want you to describe a meeting between three Stellenbosch psychology professors and the Prime Minister Dr Verwoerd concerning how strongly they felt about keeping Blacks out of SAPA and that the Group Areas Act could be used to ensure this. If you can just expand on that.

PROF NICHOLAS: Okay, what occurred at this meeting was that there was a reluctance on the part of Dr Verwoerd to in fact extend this legislation and he felt that there were more natural means of excluding Blacks than would be served by expanding this legislation, which as you would know, really was quite wide already. What he did do then though was to try to force all professional associations to keep their proceedings separate by race on the pain of having whatever subsidies they might gain from the govern-

ment be kept back should they not do this.

Most of the professions did not adhere to this and the State then backed down on that and allowed professions to some degree to manage their own affairs in this regard. So Dr Verwoerd did not see to the request at that time to extend that legislation.

But to your previous comments I just would like to add that during this period the person who was regarded as the exemplar of psychology and the doyen of South African psychologists was somebody called Dr Vischeville(?) who still is a major icon today in South African psychology and he was really the main person responsible for keeping out Blacks initially. And the curious fact about South African psychology is that the progressive or those who were regarded as progressive White psychologists probably did as much as the rightwing ones to keep Blacks out of the profession. So he was one of the main activists trying to keep people out and who Ms Naidoo reported to me was the main actor in her humiliation, trying to qualify to be in this Association.

One should also remember that to the rightwing psychologist it seemed pretty obvious that this was really a White society because their main honorary member was Dr Verwoerd himself who obviously resigned after they admitted the first Black psychologist after these years of debates and votes on the matter.

MS GOBODA-MADIKIZELA: You know, I would like to know from you as to how much does their mandate of the your new organisation focus on racism? The reason why I'm asking that it's mainly because really what we deal within our databases like the techniques of this profession in particular, you know, psychological assessments and some of the strategies that were used in getting information out of people like torture, as given by the example which is cited by you from Dr Saths-Cooper, were based on the theories of psychology, so I see now there's a new name. Basically my question is, what is the thrust of your new organisation?

PROF NICHOLAS: I think that the new organisation is still struggling with the realities of a New South Africa. There are some efforts, there is a committee that deals with equity and redress but I'll really have to be frank and say that I believe that within the organisation the majority of membership could still be regarded as conservative. I think that this would be reflected in the content of what we teach in psychology and that there is really far too little focus on the larger social problems that we need to address, the

problems of racism and the problems of oppression. And I think the slowness of change is really facilitated by the lack of visibility and scrutiny and that this Commission is really nationally one of the main instruments of visibility in the country, and to me personally has succeeded beyond my wildest dreams, but I think also possibly beyond the wildest nightmares of many other people. And I hope that even when this Commission ends that some ways would be found to continue this visibility.

So I'm saying that I think this organisation is struggling with these issues, that I think many people might be feeling that they are doing enough but that a lot more pressure needs to be placed on the organisation to be accountable and to redress the ills of the past.

MS GOBODA-MADIKIZELA: Thank you very much Professor Nicholas. I'm sure other colleagues would like to ask a few more questions. Thank you.

DR RAMASHALA: Thank you Chairperson and thank you Lionel. It's delightful to see you here having been involved in this transformation of the organisation that has got so much history.

Lionel you mentioned the issue, the theory of Black intellectual inferiority. Now this theory is perpetuated not only in this country but in many other countries such as the United States and in Europe as well. It's kind of generic in psychology. There were institutions that assisted this notion of Black intellectual inferiority. What were the organisations or parastatal institutions and organisations that assisted in perpetuating this theory in South Africa?

PROF NICHOLAS: I would think that the main ones that could be identified would be the National Institute for Personnel Research, which is now defunct and subsumed in the Human Sciences Research Council which seemingly has made a total about-face. But, for example, in terms of the test used to assess intelligence, for many years there were these separate tests and they were just indicated by "NB" for "Nie Blanke" in front of the designation for the test which were then listed in international directories. But I think that the NIPR has an even further responsibility in their inhuman tests on miners. They did much of the research, a lot of it which is still secret and I think that these organisations should still be required to be accountable.

It's not easy to pin people down because often even while presenting these ideas of Black inferiority there were some people who would then indicate these as examples really of saying, no there is equality but there are contextual conditions for in fact allocating inferiority. So often the cases weren't clear cut

but there certainly is enough information to show that within government and parastatals there was a promotion of this idea.

For example Dr Fick had to be restrained from visiting schools and testing all these people because he had a mania for finding these intellectually inferior Black children and there was a notice from one of his departments to not allow him to go into them anymore.

DR RAMASHALA: One of the problems with that theory of course is that it excluded, it tended to exclude a large number of people from certain important opportunities and perhaps there still is that mindset amongst some people.

Lastly Lionel, you mentioned that sometimes even progressive people within the organisation of psychology perpetuated some of these exclusionist practices. What are the subtle ways in which racism operates in liberal institutions today?

PROF NICHOLAS: Well I think that the most blatant way in the centres of where psychology is taught is really that for a long time psychology departments would be all White psychology departments in certain universities without any consideration that that would be a problem for example.

I remember being invited to give a talk to the Psychology Department at Stellenbosch University in 1990 and I arrived early and took a walk along the corridors and saw that the photographs of Verwoerd and these others professors who promoted racism were still on their walls and in fact started my talk to them about this fact. Needless to say I was never invited back to give a second talk that department.

The other subtle ways is that within different professional systems it becomes comfortable to only deal professionally with your own kind. You don't give a thought to how that might reflect in the development of your profession, especially one that largely excluded Blacks and to this day is still around about 90% White. So not very much credence was given to the efforts that were needed in fact increase Black empowerment within psychology and also Black leadership. The Black groupings that were formed to promote this position often found censure from both sides, from White leftwing as well as from White rightwing psychologists and I think there was far too little sensitivity and there is too little now even to the need for training Black psychologists and also to promote Black leadership within psychology.

DR RAMASHALA: Thank you Lionel.

CHAIRPERSON: Thank you Professor Nicholas.

MS GOBODA-MADIKIZELA: Can I just read out something from the University of Natal Department of Psychology before you leave the platform. They've sent a message to the health sector hearings where they say,

“We have discussed your invitation and are of one mind in our support of the process of self-examination in the Health Sector with regard to past policies and actions of individuals and institutions. We look forward to the hearings having a positive impact on training and practice amongst all health professionals including psychologists. We would be grateful if you could keep our Department informed about the hearings and any recommendations that may result from them.

With very best wishes”.

PROF NICHOLAS: In response to that I was also curious about your messages of support, I think from Orange Free State and Potchefstroom yesterday that you mentioned because recently I had a conversation with somebody who used to lecture at Potchefstroom and he told me that his students reported him for teaching the doctrine that Blacks and Whites are equal in his department, and he was told to take it a bit easy at Potchefstroom.

I was also invited to Orange Free State a couple of years ago and they also seemed quite comfortable with their particular status quo. So while I think it's encouraging that this process is supported, I wish that these departments would perhaps put their money where their mouth is.

CHAIRPERSON: Thank you Professor.

MEDICAL SCHOOL SUBMISSIONS - WITS

CHAIRPERSON: We go on to the Medical Schools submissions, and if I can call Professor Jenkins and Professor Max Price. Professor, for the record will you just stand and tell us who you and where you are coming from?

PROF PRICE: Thank you. I'm Max Price, I'm the Dean of the University of Witwatersrand Faculty of Health Sciences.

PROF JENKINS: I'm Trevor Jenkins head of the Department of Human Genetics at Wits and with an interest in medical ethics.

MAX PRICE: (sworn states)

TREVOR JENKINS: (sworn states)

CHAIRPERSON: Max you're going to be presenting for the University.

PROF PRICE: I'll start. Can I clarify the time limitations. On the programme there are three medical schools listed and do we have 15 minutes?

CHAIRPERSON: 15 minutes each.

PROF PRICE: We have of course made a written submission and received some questions yesterday. We'll leave that for you to ask which questions you want us to address, so I will take out some of the highlights - issues from our submission.

The first point that I'd like to make is that this is a process initiated by yourselves in response to your request in the Faculty and has now received faculty support and is a form of Faculty submission rather than an individual submission, and the process itself has been a useful one in uncovering a lot of issues in the Faculty and we'll return to that at the end.

The submission relates to what I think is one of the TRC's mandates, namely to understand the societal conditions that could have allowed violations to take place, violations in which health professionals participated and to make recommendations that will relate to faculties of health sciences, medical schools for the future.

The submission from Wits is an attempt to record a very summarised and incomplete history of

apartheid in medical education, and I again need to emphasise that this is not comprehensive in the time available and we recognise the many omissions and would be happy to supplement this preliminary submission.

It's a record of apartheid in medical education as well as the Faculty's response to that in the belief that this was part of the context which contributed to the values to which our graduates ultimately subscribed.

We look specifically at the failure of the Faculty to address human rights and ethics as a substantive and formal component of the curriculum prior to approximately 1983 and '84 at which point it was introduced formally, and we make recommendations regarding the incorporation of human rights culture and ethics as a subject in the teaching of health science students for the future.

We also highlight the need for academic institutions to guard their autonomy and independence from political authorities so that they can maintain a critical stance with respect to government policy.

In our submission, as well as in some of the others we've heard yesterday and today a key theme is the tension between what is the responsibility of an institution or an organisation in civil society, and what is the responsibility of government and legislation constraints set externally. And a lot of what we are talking about in our submission is that tension.

The discussions in the Faculty, triggered by this submission as I said, have revealed that there is still an enormous amount of anger and bitterness within the Faculty and in the end we will return to how we think this should be addressed.

The first set of issues is the relationship between university and government, and what I am going to do is select just a few examples that illustrate this relationship to help understand what the possibilities are for a Faculty and what the constraints are.

In most faculties of medicine, and certainly in ours, more than half of our staff are employed by the province, the provincial health authority, not by the university. They are appointed as joint staff but all of the clinical staff in fact receive their salaries from the Province, their conditions of employment are determined by the Province and discipline is managed by the Province. And so the University has unfortunately limited control and authority over some of these issues.

One example that illustrates this is the selection of people and particularly the selection of chairs,

and we give an example of a professor, a man of colour who Wits, at the selection committee wished to appoint as the head of a clinical department in 1987 and the representative on the selection committee from the Province vetoed this. The Faculty responded by refusing to make any other appointment, although there was an eligible candidate until in fact the candidate concerned withdrew his application 18 months later, at which point the chair was filled by another candidate.

In other words, even the appointment of professors in the Faculty are constrained, both sides of course have a veto, the university has a veto as well, over that process. Promotion of staff within the Faculty was frequently subverted by irrelevant considerations like race and political affiliations and anti-apartheid activism, and the case of Dr Joe Veriavo(?) who has helped us prepare this submission but unfortunately is overseas at this moment could not be here, is a case in point.

Staff who were active in expressing opposition to the provincial policies were often victimised in other ways besides promotions. One example is of a Faculty member whose sabbatical was terminated at short notice, forcing him to resign because he couldn't get back in time to take up the job, to continue working in the hospital.

Another example arises out of the protest letters written by doctors at Baragwanath protesting at the conditions of health care at Baragwanath. The letter was published in the Medical Journal and the Director of Hospital Services called in all of the 101 doctors and asked them to submit a letter of apology to the Medical Journal withdrawing what they had said or else their jobs would be terminated and those who were on short term contracts like interns and registrars who relied on reappointments on an annual basis would not be reappointed.

The submission details some of that case which resulted in many of the doctors writing a letter of apology because otherwise they would have lost their jobs. Others took the province to court and one in fact, was reinstated by the courts as a result of this. But in the mean time had lost something like a year and a half of clinical time, experience and employment.

Some members of the Faculty would have liked the university to take a much stronger line of opposition to this sort of action by the provincial administration.

Perhaps the Faculty should have refused to fill the posts where it's chosen candidate was blocked. Perhaps senior staff should have resigned in protest against provincial harassment of staff. To have done so might

well have resulted in a post being vacant for a long period of time, as in the case I mentioned, with possible harm to patients and students whose teaching would have been compromised, but perhaps on the other hand it would have precipitated an earlier change in policy and this is obviously one of the issues we have to think about in thinking about the future.

The issue has come up several times in these hearings of discriminatory employment practices, salaries, benefits etc and again I think it worth highlighting that this is the sole discretion of the province. In 1969 for example, Black interns were earning roughly half of what White interns earned and African women earned less than African men within the spectrum of doctors. Black staff did not get travel allowances or thirteenth cheques, they received 25% less leave. These policies obviously created tensions in the Faculty and certainly black staff believed that the university did not bring appropriate pressure to bear on the authorities to change these discriminatory practises.

One example which has come to light since making the written submission is of a group of students who attempted to get White staff to sacrifice some of their salaries into a pool which would be used to equalise salaries across staff and this was not supported by White staff at the time. So although the responsibility for salaries and benefits is a provincial one it could certainly be argued, and I think it's true, that the university did not protest as it might have.

That section then had related to the Department of Health or the Ministry of Health, its provincial arms and the employment practices in the Faculty given that we have joint staff.

The next section looks at the relationship with the Department of Education and Ministry of Education, another branch of Government, and here we deal firstly with the issue of submissions and the extent to which the university was prevented from admitting Black students, African students in particular without ministerial consent. That I think has been covered by some of the other submissions yesterday and I won't repeat that.

You also saw some graphs of student admissions yesterday and so I won't repeat that.

After the 1959 Act which closed White universities to Black students we had very few Black students until the mid '70's when it started increasing again when ministerial consent was granted a little more easily. In the late '70's the Faculty embarked on an affirmative action programme which I can detail at great length if you're interested in the questions, some of that is covered in the submission. S o

the question of submissions was the first question to do with the Ministry of Education. The second relates to the segregation and training of undergraduate and post graduate students. This segregation was again largely the result of the segregated hospital facilities where Black students and doctors were not allowed to treat White patients although White doctors were certainly allowed and required to treat Black patients in the Black hospitals. Again, although primary responsibility must rest with the Province and the Separate Amenities Act which segregated the facilities, it can again, and it has been argued, and I think the Faculty accepts that it did not do as much as it should have and could have in protesting this segregation. The protest only really got under way during the 1980's and eventually became quite substantial with marches, sit-ins, attempts to desegregate the hospitals through just civil disobedience campaigns, but I think that was motivated as much by the Mass Democratic Movement and its attempts and the attempts of organisations like NAMDA to desegregate the facilities, as it was an internally driven process. Up until that point I think it was a process driven by individuals rather than an institutional policy.

I'm moving on to the next section which deals with the question of admission of patients and care of patients in segregated facilities. Again we've heard quite a lot about the unequal care available to Black and White patients, the differential resources given to hospitals and clearly a form of discrimination which affected the Faculty since - we have for example, six hospitals in our complex which were segregated by race.

One of the areas where the Faculty has been criticised for its policy with respect to this unequal distribution of resources and which I think is valid, is the attitude the Faculty took to the building of the new Johannesburg hospital which was planned in the 1970's, where it was argued or it can be argued, that given the lack of resources in the Black hospitals, the Faculty should have refused to see a new hospital built which would have been for Whites until better facilities had been provided for Soweto and for the community served by Baragwanath and Coronation hospitals. Nevertheless the Faculty enthusiastically embraced the idea of a new academic hospital which was going to be located next to Medical School in central Johannesburg.

There had always been a few voices protesting the segregation of health facilities as I say, the real campaign gained momentum in the '80's and is described in some of the appendices.

One example where the Faculty did exert its power, perhaps belatedly but nevertheless an exam-

ple of what the Faculty perhaps could have done if it had wished to at an earlier stage related to the episode around the JG Strydom Hospital, which after the Tricameral Parliament was instituted, Health Affairs were transferred and became an Own Affairs activity and JG Strydom, as a White hospital, was transferred to the Own Affairs Department of Health instead of the General Affairs where it had previously been. All the other academic hospitals remained under General Affairs. The purpose of transferring JG to Own Affairs was in fact to keep it White because under General Affairs and as an academic hospital that would have been harder to do. The Faculty responded by withdrawing academic affiliation and association from JG Strydom and it immediately lost almost all its staff and was unable to attract doctors to work there and so it was then transferred back to General Affairs and the Faculty reestablished its affiliation.

I think what that episode illustrates is that there were avenues which the Faculty could have exploited better in exerting authority or in challenging the State and its authority and sometimes these were used, very often they were not.

The Section three of our report gives some examples of protest actions which occurred in the Faculty, I've mentioned the ...(indistinct) doctor's complaints. It refers to the creation of the Professional and Ethical Standards Committee in 1981 which met frequently, and still meets, throughout the last 16 years. The issues which that Committee dealt with, I should say that committee was set up as a direct response to the Biko doctors' affair and a perception that the Medical Association and the Medical Council could not be relied upon to protect ethical standards.

Our Faculty Committee looked at issues such as legal guidelines for health professionals in contact with police while treating unrest patients. We addressed the issue of clinical independence of doctors in treating prisoners, a legal survey. We addressed the question of medical students in national service and issues of conscientious objection, doctors ethical and legal responsibilities in times of conflict, guidelines for treating voluntary total fasting, in other words hunger strikes. These guidelines were created for the use of our faculty members who were treating patients in our hospitals but certainly we evangelised with those guidelines to district surgeons, to MASA, to other doctors and international literature, and a particular feature of that has become accepted by the international medical community, namely that part of one's medical responsibility in treating a detainee is to refuse to allow them to be returned to the conditions of

detention. It came to be known as 'Kalk's Refusal' after the author of that article.

The committee developed a patients bill of rights which we tried to get distributed to the hospitals in which we work, addressed issues of handling of children in detention, the protocol for the medical examination of detainees and issue of confidentiality of medical records which became an issue because the police frequently raided our hospitals and clinics to obtain records of people who had been injured in unrest on the grounds that if they had been injured they must have been guilty and there is an annex describing in some detail the experience of Alexandria Health Centre and in particular, Dr Tim Wilson in protecting patients' records and the Faculty's attempt to support that.

I won't go into that at length because I think it's easy for this to become a white wash, it's easy to present what was done because those things can be listed and then it looks like the Faculty made a substantial contribution resisting apartheid medicine whereas in many respects, the things that were not done, the sins of omission are not recorded, and in going through archives and in going through minutes of meetings etc, those things do not appear and also tend to be omitted from this. So I think to maintain balance, I'm not going in this submission through all of those minutes of meetings and issues that were taken up.

I want to turn finally to what I think is the question of the climate that was created in the faculty and how that contributes to the values that students acquire. This relates to our recommendations in the last section, and if I may just read this last section then.

Rooted in the colonial racist society of the last 75 years, the Faculty of Medicine colluded with many features of apartheid medicine, protested against others, provided space for individuals to challenge the system, but did little that would have put itself at risk to present a serious challenge to segregated health care; constraints on student selection, restrictions of student access to clinical teaching material and gross human rights violations that were going on all the time. Yet the Medical Faculty was not a monolithic collaborator. Aside from individuals in the Faculty frequently including the leadership of the Faculty, the Faculty created committees such as the Committee on Apartheid and the Professional and Ethical Standards Committee which bombarded the authorities, the media and the staff and students with challenges to promote equity and human rights. In considering what recommendations we could make to avoid health professionals be-

coming participants in gross human rights violations or even tainted by them through a failure to challenge the perpetrating authorities, our experience points to three aspects.

1. The teaching of ethics, in other words the sensitising of students to a broad spectrum of ethical issues throughout their careers as undergraduates and postgraduates and providing them with the skills for conceptual moral reasoning, to deal with the many moral issues which confront them in medical practice. Professor Jenkins has managed that process over the last decade and continues to develop that and if time allows and if you're interested we can expand on that a little.
2. Creating a respect for everyone's equal human dignity. We believe that a crucial factor contributing to the role played by many individuals in resisting apartheid was not the substantive content of courses on human ethics or human rights, but the value system they observed around them and imbibed from the Institution and Faculty members. In one sense this should be easier than it was in the past. The hospitals are no longer segregated and patients no longer obtain unequal care solely on the basis of race. But other forms of division replace ethnic hierarchies and health care is certainly neither equal nor equitable. Those patients receiving inferior care are also frequently found in hospitals which are overcrowded, work loads are perhaps heavier than ever and where staff morale is low. All these factors make it harder to demonstrate the concern, sensitivity and equal respect for each patient's dignity. This is the context in which it is easy to start thinking about patients, or some groups of patients as them, different from us. That is when the door is opened to regarding them as not entitled to the same respect, care and rights as us. So it's really the environment that we are saying creates the value system which students imbibe and which they continue to practise afterwards.
3. Creating a relationship with the state which protects the university faculty and individual staff and students should they become critical of state actions, and within that, fostering the courage to challenge authority. We believe that the activism of the 1970's and '80's, the many protests and petitions and public statements by deans and faculty members, the student activism, the tolerance by the university of dissent, even if it did not support those

issues, however limited their real impact on policy, however limited all these issues were on policy, nevertheless they all contributed to the maturation of cohorts of health professionals who generally felt concerned about apartheid, about their role in challenging or perpetuating apartheid and about their responsibility for protecting patients' rights against the state. Unlike designing a curriculum or funding a senior post, this liberal milieu cannot be easily guaranteed.

There are certainly lessons relating to the need for autonomy of the university from State control, not only in relation to the Department of Education but also the Department of Health.

The control over appointments is an essential element of academic freedom, as is the freedom to protest and challenge without fear of losing funding and subsidies.

Furthermore the universities have to ensure they remain tolerant of dissent and encouraging of challenges to any authorities.

The postscript to our submission discusses the internal process and it's just two paragraphs I'd like to ask Professor Jenkins to report on that.

CHAIRPERSON: Max I wonder if I can ask academic question of the Professor and deal with other questions as well.

PROF PRICE: Sure.

CHAIRPERSON: I have three questions and perhaps the others may have a few others as well. The first one relates to something that was said yesterday by a young man from KwaZulu Natal who joined the military medical core and the impression was created that young medics, medic in the sense of someone who went as a male nurse, not a medical student, was sent to Black hospitals, Black clinics to practice. Dr Barker gave a different viewpoint this morning. I want to ask the question in relation to Alex Clinic. You've mentioned the long relationship that the University had with Alex Clinic and I know Dr Wilson's here as well, so I welcome him. This question relates to pre-1985 essentially. What supervision was there of students who went to Alexander Clinic to practice primary health or to learn about primary health care from the University?

Number two is a situation pertained at Alex Clinic in 1984 and 1985 where almost the same

number of babies were born as at the Johannesburg hospital but the environment in which it took place was one of a big room, perhaps the size of many of our bedrooms with a toilet sitting in one corner. Did the University ever take any note of that in developing the culture that you're talking about?

Can I just pose all my questions. The second one is to do with your Professional and Ethical Standards Committee. Very important issues were taken up, debated within the University. My question is, how far was that taken beyond, if you like, the walls of the university into discussions with other universities with the SAMDC, with MASA?

Then the third one relates to what you were saying Professor Jenkins was going to talk about, which is, from your submission it appears you consulted widely and clearly what comes out is that there's a lot of anger, particularly amongst Black professionals within the University. What is the University going to be doing about that in the future? Thank you.

PROF JENKINS: Mr Chairman may I answer your third question first then it won't disturb my train of thoughts as much. In the process of soliciting views from the Faculty and past students in preparing for this submission, it became clear as you said, there was a great deal of anger about what these people perceived was an inferior education that they'd reserved at Wits. This anger is directed against the Health Sciences Faculty as much as it is against the Provincial Authorities, if not more. This is compounded by their view that the discrimination in health service delivery, in employment practices and in status between White and Black hospitals persists today. What's changed is a common question that we heard, what's changed in the last seven years?

There is disappointment that senior members of the Faculty who were seen to have supported apartheid medicine, have not acknowledged the affront called by the Faculty to the dignity of it's Black students and staff. And in my understanding of the philosophy behind the TRC, I have the idea that for the TRC to be effective, to be fully effective, requires that the processes taken into the places where people live and work and interact. We need in fact a mini-TRC in our institutions, and we believe that this mini-TRC process has already been triggered within our faculty in these last few weeks.

A great deal of hard work though and creative thinking will undoubtedly be needed if members of the Faculty are to be reconciled with one another. The privileged members of the Faculty, who were not the victims of apartheid in the teaching hospital settings, must listen to the accounts of their Black col-

leagues and former students. They must be reminded of the many ways in which they wittingly or unwittingly collaborated with the system. They must be prepared to experience and share some of the pain and hurts which their colleagues of colour experienced because of an accident of birth. In such a process we believe we will all undergo changes and experience healing and only then will the Faculty be able to develop into a cohesive structure capable of producing well-trained health care professionals motivated to serve the South African community.

So we can't really over emphasise the importance of this submission being a beginning of a process which we are committing ourselves to pursue.

Then do you want me to answer the other question Max?

The Professional Ethical Standards Committee which has met for 16 years now regularly has done very little, I must confess, as far as relationships with other medical schools are concerned, we heard from Francis Ames yesterday, that they constituted a similar committee at about the same time, namely after our disillusionment with the record of the SAMDC and the MASA, and certainly we've had very little contact with the SAMDC or the MASA in any organised way. I might say that we have often used the journal of the MASA to bring our viewpoints and publish comments on events of the times and the SAMDC have certainly been included in criticisms from the Committee. The Registrar has been brought over to the Medical School to participate in the teaching of ethics, certainly, and has been challenged by students in those sessions.

The supervision of students at Alex, are you happy to deal with that Max, because I have some views but not many?

Well I just know that during times of crises there as a member of staff with colleagues we would go along there and certainly help supervise in the evenings and at weekends. Whether they got good supervision from a geneticist or occupational medicine professors who I remember there, I don't know, but certainly we stood alongside them whilst they were confronted by some of the nasty episodes during the mid-fifties.

I don't know anything about the deliveries of babies there, perhaps you do Max.

PROF PRICE: Mr Chairman I would rather leave this question for Dr Wilson if he is going to have any opportunity to present because it would be a more honest reply. I don't have enough first-hand knowl-

edge.

I would like to make a different point which may sound like an excuse but I think needs to be borne in mind and that is that the Faculty has no funding to deliver health services, in the same way that we do not employ any doctors and they are all employed by the Province. All of the resources for delivering health care are provincial resources. The Faculty is funded by the Department of Education to run some of the laboratories and lecture theatres and employ pre-clinical staff, which makes it very difficult to provide a sustainable health service which is obviously expensive and for which we have no funding.

The Alexandra Health Centre was funded by donor funds and the poor facilities you are describing are as much a reflection the inability to raise donor funds as they are a failure of the government to provide any primary care services to a community that it wished to consider illegal and not having a right to settle in a White area. So that the whole reason for having a so-called university clinic or a clinic there at all was very much to perform a function which the government was refusing to perform for a community that clearly needed health services. It had to be run out of funds that could be raised for that purpose and these, both the supervision and employment of doctors to supervise students, would all have been inadequate I believe because of the lack of resources.

I don't want to though let the Faculty of that time off the hook altogether. It seems to me again that the contrast you are drawing is between the facilities available at a White Hospital not very far away, and the facilities in a Black Clinic and the faculty perhaps could have done something to get Black patients into the hospital, but the control of hospital services were under superintendents who were not joint appointees, have no accountability to the faculties and who at times called the police to keep our own staff out at times of protest. So it's hard to know quite how they would have responded if there had been a concerted campaign. But I don't think there was a concerted campaign and so I think your point stands as a criticism of not doing enough to equalise the facilities and resources.

DR RAMASHALA: Professors, the question I'm going to ask also relates to the next two submissions. UNDN and the University of Pretoria. There is something particularly problematic about these submissions, and I'm obviously prejudging the next two submissions. You identify three categories of recommendations. The teaching of ethics; respect for human dignity and creating a relationship with the State.

I want to insist there is a fourth category and that is redress. All White South Africans benefited

from the apartheid opportunities. I have not heard a single person, particularly institutional submissions, address the issue of redress. I'm a Wits graduate, I knew that I could easily get through Wits because of my credentials, my grades. Most people, most Black students who were admitted to Wits and UCT for that matter during my time could have made it anywhere. So you essentially got the cream of the crop. I consider the issue of missed opportunities as a gross human rights violation. I have heard apologies all over South Africa about this and that but I've not heard a person saying - yes actually one citizen who is a home-maker who called our office to say I'd like to contribute to the Reparation Fund, but I think it is the responsibility of the academic institutions, not to look at what they do for students who are already admitted, but what to do with students who have missed out from the beginning. I think you need to be more creative than that. I think you need to make a much more serious commitment because a student who's admitted into the Medical School or Wits in general, will make it. What do the academic institutions propose to do to reach out to those students from the very beginning who won't even have a chance to be admitted? I hope you understand what I'm trying to say.

There are very innovative ways of academic institutions who actually start with pre med, when I say pre med, I mean pre university courses in Science and you name it at the beginning. I think it is a way for universities, all academic institutions to deal with the issue of redress and I sound passionate partly because I am angry at Wits. I think it is very important to make that serious commitment and not to wait for students to be admitted to Wits. Create that opportunity at the very bottom of the realm. And having said that, I'd like to get your opinion on that.

CHAIRPERSON: Max I wonder if I could ask Hlengiwe also to pose a question then both of you can deal with those questions.

MS MKHIZE: Thank you Chairperson. Maybe before I ask you a question I would just like to read out something from Redress which is an organisation which is based in London and it is thrust is to seek reparation for survivors of Human Rights violations. Basically they've written a letter and what they've said is that,

“I would like to express Redress support and encouragement for this process which we view as extremely timely and important”.

Those are some of the messages we've got. Coming to a specific question, yesterday we listened to a

young man who is now a highly qualified doctor, Dr Ratamane who was talking about his experiences in one of the so-called open universities, actually not one, two of the so-called open universities. My specific question to you really is that over the years, the world even at the time when there were campaigns for academic boycotts, there were universities who were treated with exception, like Wits University will be one of them, but for the past two days, in our case including what is in our database we are living with this contradiction, almost being schizophrenic getting a progressive message which has got a stance against human rights violations and yet the reality as I've made an example of a person who is today a specialist who went through a difficult time in these institutions, one is left with nothing tangible which gives you a sense of hope that especially institutions of higher learning are lucky, even in future, to be a source of a different way of doing things as against the apartheid grand plan of creating a niche for certain categories of people. Creating a situation where I would say at a certain point, maybe it became almost impossible for them to empathise. Because neglect of patient care, I still maintain is like a serious deficit where you cannot empathise with a person at a deeper level, who maybe you cannot relate to his whole world view or his creation as a person. So I would like to hear your views on that.

PROF PRICE: I'm not sure that I've fully understood the second question but I leave that for Professor Jenkins and I'll try to address the first.

I think I need to say, I suppose firstly to comment on Dr Ramashala's view of what is a gross human rights violation, because I think that I would be concerned that we devalue and demean the awful experiences of many people who have experienced what the law has defined as gross human rights violations, if we put it into the same category as students who have not had an adequate support-system in tertiary education to ensure that we compensate for a bad schooling.

For example, I fully agree with the sentiments, I just want to make a distinction between what I think is the focus of our submission and what I think is the focus of the question. I think the focus of our submission has been around the grosser human rights violations and has been trying to understand what is the culture and the climate that allowed that to happen.

This sort of question is looking more at the question of how has discrimination - what can we do to redress discrimination and inequality? I feel just as passionately as you do Dr Ramashala that we need to do this. It's not in the submission because it didn't seem to me it was the key focus of the submission.

I will just say very briefly that we don't see this as something that a single faculty should take on because students generally haven't made those kinds of decisions at a very young age, so it's a university activity rather than a faculty activity. The university identifies and has done for several years, schools in Black areas, townships and in rural areas, provides specific resources to fund laboratories for example to teach science teachers, teach English and Maths teachers, offers opportunities for students to come on to campus on Saturdays and special classes are there so there is a programme in place to try to improve the quality of matriculants so that we can take them without having to make allowances for their marks in such a way that they will not succeed at university because you've taken people who actually are not prepared. So there is firstly a programme aimed at the schools.

Secondly, for people who are accepted into our faculty, there is programme called an academic development programme. In the 1980's we had a bridging programme, an extra year which I think you heard something of yesterday and you heard that some of the people who went through programmes like that at Natal University and also at Wits, found it demeaning because they were regarded as second class students, because they were separated into this special class. At Wits we abolished it for that reason in the mid '80's. We restructured it to be a tutorial support programme. We're now of the view that we again need to reintroduce it and in 1997 we do have for example, 25 students in a bridging year which is run by a part of the University called the College of Science and is a feeder programme for all the science-based faculties, engineering science, medicine.

Then there is a tutorial and mentoring programme whereby we link senior students with junior students in order to help them deal with the many social disadvantages which they have coming into a completely foreign environment, accommodation problems, funding problems, transport problems, and so that also has to be addressed, not just the academic issues.

Nevertheless, in spite of the fact that we think we are attracting, we know we are attracting the cream of the crop and we are providing all the support, it has to be said that we haven't found the formula. We still have very high drop-out failure rates and it takes some students from disadvantaged educational backgrounds much longer, many more years to complete the degree than others who have come from advantaged backgrounds. So it's a huge problem for us and it's the main reason that we don't have more Black graduates and we aspire to produce the Black graduates in a similar proportion to those in the

population. We can't do it by admitting people who are not going to pass, that doesn't do them any help and just costs them a lot of money in lost fees. We need to do it through educational support programmes, but we haven't yet got the answer. And I think that is one of the areas where there can be very useful collaboration with other institutions to try to find better answers.

CHAIRPERSON: Professor Jenkins.

PROF JENKINS: Well if I understood the other question correctly, what I would say is that it's very difficult in the context of present-day teaching hospitals to really get close to patients and to learn about their world views, their way of life and so on in order to be able to emphasise as you, I think correctly put it. I would suggest that this is a societal problem and not a uniquely medical faculty problem. Until we have a society which is caring for all members of it and interact at a deep level, we're not going to get to this position where I would say, privileged students will be able to empathise in the way that I think you were getting at.

I would endorse your sentiment wholeheartedly and say that it's in other institutions and organisations, community activities, churches, those sorts of organisations where these relationships can be forged, where in fact a genuine concern for the patients coming from an underprivileged background will find the caring and hopefully the healing.

Now I hope that doesn't sound too pious, but I really think that it wasn't part of our brief in preparing this submission.

CHAIRPERSON: I thank both of you for your openness. I am sure that the debates that have been started can continue at lunch time and at this afternoon's session. So we hope you'll stay for that.

MEDICAL SCHOOL SUBMISSION - UNIVERSITY OF PRETORIA

CHAIRPERSON: Can I ask professor du Plessis to come forward. Welcome, can I ask you to stand and introduce yourself and Wendy will help you in taking the oath.

PROF DU PLESSIS: My name is Professor Deon du Plessis, I'm a dean of this faculty for the last 20 months at the University of Pretoria Faculty of Medicine.

DR W ORR: Thank you Professor du Plessis and I want to thank you for being the one university who sent us a submission unsolicited and we're very grateful to you for that. Could I ask you to raise your right hand and take the oath.

DEON DU PLESSIS: (sworn states)

CHAIRPERSON: You can continue.

PROF DU PLESSIS: Commissioners thank you for giving me the opportunity to submit our submission this afternoon. We had some difficulty getting the necessary information from the archives and from input of various members of the Faculty.

I would like to start with giving a historical background of the Faculty of Medicine being an Afrikaans or traditional White Afrikaans faculty of medicine and university, and its relationship possibly due to the State.

In 1954 the general accepted pattern of the primary, secondary education in the country was separatenistic in nature. At the time it was argued that universities should either be fully integrated or fully separated as a continuation of the apartheid pattern of basic education. These arguments were informed by the political ideologies at the time and in turn served to shape the separatenistic nature of the education at the University of Pretoria until the late 1970's when the people started to realise that this nature of education should change.

The University of Pretoria was subject to the provisions contained in the Statutes of the Republic of South Africa Education University Act No 61 of 1955 of which a clause pertaining to funds reads as follows:

“Subsidies to the universities: The Minister in consultation with the Minister of Finance may out of the monies voted by Parliament, for the purpose, grant subsidies to the university...”,

and I think I won't go any further.

The extension of University Education Act No 45 of 1959 affected even greater segregation of university education and it is in my submission. The University had no option but to conform to the policy regarding the admission of students formulated by the government at that time. However, in as early as the 1960's the University made available its expertise and lecturers to help institutions serving disadvantaged communities with medical education and in '62 approval was granted for the University to assist in the education of nurses lectures at the University of the North.

The Minister of Education and Culture, also in response to a University request, approved the

cooperation agreement between the universities in the Transvaal and the Department of Hospital Services with the regard to the training of non-white nurses at the Leboni Nursing College at the Kalefong Hospital.

Throughout the years the Medical Faculty, as put forward by my colleague, Professor Price, as such was strongly linked to the Provincial Health Department who was responsible salaries, medical services and hospital policies. Legislation dating as far back as '57 aimed at separate university education for Whites and non-Whites which contributed determining the nature of medical faculties at the University of Pretoria.

The policies within the country at the time limited the admission of non-White undergraduate students to the Faculty. Until the '80's the Faculty was not allowed to register non-White students. This was among others set out in a letter to the principal of the University dated the 29th of August 1983 in which the Minister of National Education indicated that in order to ensure the optimal use of certain training facilities at universities by Black students, it was determined that no Black person could be registered for studies in medicine, dentistry, paramedical courses, nursing, pharmacology, optometry, agriculture, quantity surveying at the University of Pretoria without prior consent of the Minister of National Education for each case.

The University was requested to bring it to the attention of all Black persons wishing to obtain admission to these courses and to refer them to various specified institutions, namely the Medical University of South Africa, University of Natal, Zululand, Fort Hare and the University of the North. Unfortunately Chairperson, this meant that the University was prohibited to register Black undergraduate students in the Faculty of Medicine as referred above.

In the same letter it was indicated in terms of Section 25(2) of the University Act 1955, there would at that stage be no quota for the registration of any students other than White students at the University of Pretoria. Non-White postgraduates students, however, were admitted to the faculty of medicine at the University of Pretoria from '83 and mainly as I can recall, worked at our Kalefong Hospital. In December 1985, the University was informed that the provision prohibiting the registration of students in the faculties mentioned above without approval by the Minister was abolished. However, it was still compulsory for the registration of such students to fall within the quota prescribed in respect of each

university by the Minister. Since '87 the Faculty has actively worked towards ensuring the admission of Black students, a process which included the changing of perceptions within the faculty, taking firm standpoints against any form of racial discrimination and the Faculty also declared itself in favour of academic freedom and non-discrimination.

Following this, a policy was issued by the vice-chancellor and principal in 1989, 14th June for the whole University, and I quote,

“The University of Pretoria is an autonomous institution that does not discriminate on the basis of race, sex, religion, colour or ethnic origin, aids, physical handicap or in its administration or its education policies, etc”.

In spite of the above statement, the Faculty had limited success in recruiting, and I must stress this Mr Chairman, we had limited success in recruiting Black students, possibly due to our being an Afrikaans faculty in the University and I must point out, at the present time, we as a university are busy with revision of our language policy.

And secondly the question of old perception still existed. It possibly explains a time lapse between the first registration of a Black undergraduate student in the Faculty in 1989 and the official approval for the registration of non-white students in 1985.

In December 1991 the recruitment programme was well underway and in 1992 a total of 54 students from Black communities were enrolled at the faculty. The registration statistics over the period '89 to '96 showed a steady increase in the number of Black students registered at UPM Medical Faculty and in 1996 we had 1437 Black students in our Faculty of Health Sciences.

The policies had an input in student admission Chairman. Black students were only admitted in the 1980's as referred to you earlier on. Since then there has been no discrimination against students who did enrol, and no additional limitations were placed on people. Concern expressed in '92 regarding the admission of Black students who were not as well prepared as their White counterparts to reserved position in the Faculty of Medicine at UP were noted by the Principal and Council. However it was pointed out that University was obliged to reserve a number of positions in the Faculty of Medicine for Black students in order to render a proper service to the wider community and to ensure that it does not remain an all White faculty. And I'd like to refer to that as to what we call a category for our disadvantaged

students and for the current situation we've got between 50 and 60 places.

It was further acknowledged that such students had not had the same education opportunities as my colleague already referred to. It was clear that admission criteria, language and standards should not be used as reasons to deny prospective students access to the faculty.

In September '82 the Council decided, and I'd like to focus on non-White postgraduate students to the University, and that's to give assistance and guidance through its lectures on other appropriate ways to students of other races enrolled at the postgraduate levels at other universities as requested by them. Such students may, as justified by circumstances have full access to facilities at the University of Pretoria at postgrad level and will be assisted in every possible way to reach the highest possible academic standards. This assistance and guidance as clearly offered on behalf of the University will ultimately confer or award the degree or diploma.

On the 12th of August '83 the admission of non-White doctors as registrars...(intervention)

CHAIRPERSON: I'm sorry, may I ask you to summarise the rest of the document because...(intervention)

PROF DU PLESSIS: Thank you Mr Chairman. Perhaps I can just summarise by saying, how many minutes have I got left, two minutes? Well perhaps I must end by giving you a summary of our possible recommendations. What we think should be done.

Medical schools could help to prepare health workers to deal with human rights issues in the daily practice, specifically through added values in the medical curriculum such as lectures on human rights, ethics, value systems and responsibilities towards patients and the community. This would result in a change in the manner in which procedures are interpreted.

Secondly, changes should be made to the medical curriculum and I refer to added values which have been incorporated into our new medical curriculum Mr Chairman. The new medical curriculum of our Faculty which is integrating the basic and clinical subjects which are problem orientated, community based was recently implemented and will hopefully benefit all the students in our faculty. This is in line with the new National Health Policy as approved by the new government, specifically on primary health care, as well as on secondary and tertiary care.

Thirdly, the idea that all patients have the same value and should be considered as equals, should be upheld at all times.

Fourthly, institutional mechanisms should be put in place to ensure that the type of human rights abuses that occurred during the apartheid years will never happen again by the following, mainly the declaration of human rights should be applied consistently throughout and monitored by a Faculty committee consistently throughout and monitored by a Faculty Committee comprising staff, students, community members, to oversee adherence to that declaration. And the University of Pretoria has already instituted a Centre of Human Rights which will help to attain our objectives.

And perhaps, I would like to mention the question of redress as Dr Ramashala mentioned, and that is that our University as a whole is actively involved with a redressing programme, trying to help the people on primary and secondary school level and prepare them for tertiary education in the years to come.

Thank you Mr Chairman.

DR RAMASHALA: Thank you Sir for your presentation. In the interests of time I think what we will do, I have here a series of questions which were prepared on the basis of the submission that you have sent before today's proceedings, so I think that we will send those questions to you because we are running a little bit late.

What I do want to say that is, just as part of recommendations is something that relates to racial naming. I think the racial names in this country have become emotionally charged. There was a time when Black was an (...indistinct) category but it's since become emotionally charged and there have been voices that objected to the use of Black to identify who they are. But I do think that the idea of Non-White negates the experience of the other as something which is not White and I'm wondering if perhaps you want to comment on this just in terms of whether there is a different way in which the category, the group that you have been referring to and the University in its policy development is referring to as non-White might perhaps be changed. Would you like to comment on that?

PROF DU PLESSIS: I see no problem concerning that. We can do that and I accept your advice. Thank you.

DR RAMASHALA: It's really just an opinion yes, but thank you very much. I found your submission very informative and especially in terms of the redress that you suggested. Thank you very much.

CHAIRPERSON: Thank you Professor du Plessis.

MEDICAL SCHOOL SUBMISSIONS - UND

CHAIRPERSON: Professor Maharaj.

Professor as you're standing perhaps I can ask you to just introduce yourself, where you're from and then I'm going to wear you in after that.

PROF MAHARAJ: I'm Breminand(?) Maharaj, I'm a graduate of the University of Natal Medical School and currently an associate Professor and principal specialist in the Department of Experimental and Chemical Pharmacology.

BREMINAND MAHARAJ: (sworn states)

DR W ORR: Professor Maharaj, welcome, thank you for coming here today. I don't know if it's an advantage or a disadvantage to be third in the line of presentations from academic institutions. Perhaps it will help you summarise your submission because I think the number of issues which are raised in your submission have already been discussed. Can I ask you to take us through your submission summarising those issues which were particular or specific to the University of Natal. I think we've heard a number of issues like the tension between Province and the hospital and the differentiation in salaries which don't need to be repeated. But if you could highlight those issues specific to your institution, thank you.

PROF MAHARAJ: Thanks and the other thing is you had raised Madam Commissioner that you would like us to raise the issue about recommendations regarding human rights issues and even though it's not in

the submission, I've revised one and I can address that matter as well.

Thank you very much honourable Chairperson and Commission members for allowing us to make the submission which is based on input from the Faculty itself.

Now the University of Natal Medical School was established in 1951. The Medical School owes its existence to the farsighted vision of two medical missionaries namely Dr McCord(?) and Dr Helen Taylor, who realised that the burgeoning population of the Greater Durban area required increasing health services. It was intended to serve the Black, primarily African population of South Africa exclusively. The founding of this Medical School was part of the philosophy of the government at the time to keep racial groups separate from one another. The government run by the National Party recognised that the number of doctors to service the Black communities was inadequate. They wanted to establish a medical school specifically to train Black doctors that could treat the diseases of their own communities. This would help to keep the Black labour force healthy and to prevent the spreading of diseases to the White communities, in which Blacks via the migrant labourers and domestic workers.

During the four decades of its existence the Medical School established a fine national and international reputation for academic rigour and unwavering commitment to the community it served despite suffering years of political harassment, inequitable state funding and a chronic lack of space, facilities and equipment. It has made an invaluable contribution to medicine in providing until 1976 when the Medical University of South Africa and Medunsa opened, the only undergraduate medical training open to Black students in the country.

The Medical School was physically separate from the main campus of the University of Natal, Durban. The University has not taken as keen an interest in the Medical School as it did with the other faculties and it became a sort of foster child of the University. Since students of the Medical School are Black they had very little interaction with the other University of Natal students who were mostly White. Blacks had a separate residence and were not allowed to use the sport facilities or library on the main campus. In fact Black students were not allowed to wear the blazer with the emblem of the University. This physical separation of the differences in facilities led to a struggle between the students and the University administrators who, from the student viewpoint, did not do enough to change inequities amongst students.

The University of Natal was one of the last universities in the country to maintain segregated residences. Forcing the Black students to live in the same residence called Alan Taylor Residence, and subjecting them to adverse conditions in which to study created the place and climate for people to exchange ideas and bond together in the fight against apartheid. The University of Natal Medical School was one of the most fertile nests for political activists and future leaders of the country, leaders such as the late Steve Biko, Dr Mamphela Ramphele the vice chancellor of UCT, Dr Nkosozana Zuma, Minister of Health, the provincial premiers such as Dr Frank Mdlalose and Dr Ben Ngobane and many of the provincial MEC's for health have come from this medical school.

The Black Consciousness Movement was born at Alan Taylor Residence. Intimidation, harassment and detention by the Special Branch of the Security Police was a major problem.

The Medical School was officially called the University of Natal Non-European Section initially. After the Black Consciousness Movement started students successfully campaigned for the name to be changed to the University of Natal Black Section. Currently it is referred to as the University of Natal Medical School.

The idea behind opening a medical school at the University of Natal was to provide medical training for Blacks, mostly Africans. However the medical school had difficulty in finding an adequate number of Africans who qualified for entrance into medical school due to the inferior primary and secondary educational opportunities available to them. As a result the Administration adopted a quota system to allow for fifty percent of the admissions to be African and fifty percent Indians and Coloureds. Over the years the proportion of students body has become dominated by Indians. The change in the composition of the student body was due mainly to the fact that some students, mostly African, had to repeat certain years of study and did not complete these years of study in the allotted period of time prescribed by the University and were excluded. Some of the reasons for this included time constraints due to their political activities and the inadequate educational training prior to coming into medical school.

For many years students were admitted into a year of study called the preliminary year which was designed to provide students with better preparation in the basic sciences before they entered the first year. However this programme was abolished because it was widely perceived not to be fulfilling its purpose.

African students got the smallest bursaries from government. Some of the bursaries came with

the stipulation that once the students became doctors they had to return to their own communities to administer health services. They were expected to learn enough to treat the diseases of their own people and not necessarily learn highly technical procedures. Therefore King Edward VIII hospital, with its substandard facilities, was an adequate hospital for training these doctors. Despite these difficulties some 2,500 students have graduated from the Faculty of Medicine, a record unmatched by any other South African university. The school has also trained hundreds of Black doctors to specialist status. However this number is still woefully inadequate to deal with the health crises facing the country. Black students, most of whom are medical students...(intervention)

DR ORR: I'm sorry to interrupt you, but Solly did cover very, very vividly the conditions at Alan Taylor Residence, so perhaps you can move on to the issue of Student government.

PROF MAHARAJ: Thank you very much.

Students in their early years felt there was very little or no support for their protest activities against the injustices surrounding them. In the 1980's there was much more support for students involved in politics and this included reschedule of examinations and also the opportunity to write examinations while in detention and all the support structures. However, despite these measures, students felt that not enough had been done by the University. Students had boycotted graduation since the late 1970's because they felt that the University was predominantly White and racist, that conditions at the Medical School were inferior to those at the main campus of the University, that there were unfair rules and difficulties in transport from the residence to the medical school, that Black people were unfairly bypassed for promotions and that most of the administrative staff, secretaries, receptionists, etc were White.

They also felt there were many outstanding doctors produced by the Medical School but none of them were appointed as professors or head of department. However other Medical Schools were willing to appoint them in these positions, for example Professor Ephraim Mogokong, Professor Madivati and Professor Macqina. The students were protesting the trend of not promoting Africans although they were not saying that those who were appointed were not qualified. This went on until 1995 when the University held a reconciliation graduation and apologised for their unfair practices and actions of the past.

The high failure rate of students, especially Africans in the second year and to a lesser extent in the third year of study has been a major cause of concern. Many students were excluded from Medical School

for failing in the second year. This caused great bitterness amongst students because the Medical School appeared to be doing very little or nothing in addressing the problem. In the early days it was the exception rather than the rule that students would receive their degree without repeating second year. Many students were excluded after their first attempt at second year even though they had successfully completed the preliminary year and first year without having to repeat either year. This has also caused great economic hardship to students and their families. The nature of the courses in second year have changed but the failure rate remains a problem and students are still unhappy about the rules relating to exclusion.

In the late 1980's the University considered opening the Medical School to White students. Every province in the country had a medical school for Whites except Natal. However the students were not prepared to concede that this medical school should be opened. They argued that given the needs of the country more Black doctors were needed and since other medical schools were practising apartheid, this restricted the number of Blacks who could be admitted to their institution which the University of Natal and other institutions. The students were prepared to reconsider the position only if other medical schools opened their doors to Black students and until new constitutional guarantees were placed.

In fact the primary reason that the University of Natal could not open itself was that the students would not allow it. It is only in the last two years that White students have been admitted.

Students also fought against the conditions at the King Edward VIII Hospital, and also staff had protested against racial discrimination in the hospitals in the Durban Metropolitan area. Indian doctors had refused to accept positions at Addington Hospital which admitted White and Coloured patients on the ground but Indian and African patients were not admitted to this hospital.

Furthermore African doctors were not permitted to work in Addington Hospital. Doctors were punished for protesting against the prevailing conditions. Some were denied paid leave to go to conferences or to get further training overseas whereas other doctors would get paid leave for these activities.

It is noteworthy that students at the Medical School did not engage in protest activity which involved violence or damage to Medical School property. The administrators at the Medical School had tried to make changes at the Medical School but did not always have the backing of the University. Despite the fact that they were not always effective in changing the adverse conditions, many felt that it was important to stay and fight in whatever way they could, rather than resign and be replaced by someone

more conservative. Also the Medical School was under close scrutiny by the Security Police and the Administration would try to help as far as they could in the late '80's.

King Edward VIII Hospital was initially a hospital for African and Indian patients. However, the patient wards were segregated as well as the tea rooms and changing rooms for the doctors. In the 1970's RK Khan Hospital was opened for Indians. At this time all the Indian patients were moved to RK Khan Hospital and King Edward VIII Hospital became an African hospital.

In the early years the first difficulties doctors of colour faced were from sisters in charge of wards in the hospital who were White and who resisted taking orders from doctors of colour. These sisters were subsequently told to either resign or transfer to other hospitals. Most were transferred and the ones that remained were willing to work with Black doctors. Over a period of time more Black sisters were appointed by the Provincial Health Administration.

Conditions at King Edward VIII Hospital were inadequate and not conducive to caring for patients. The hospital was overcrowded, lacked sufficient sanitation facilities and was understaffed. The hospital was much poorer than Addington Hospital which admitted White and Coloured patients. It was difficult for the administrators to get equipment to make King Edward VIII Hospital a proper teaching hospital. For many years patients would be put on floor beds if the hospital had already reached capacity because Black patients could not be transferred to the other hospitals.

The medical equipment at King Edward VIII Hospital was often old and outdated. The new equipment that the hospital often got was that which got discarded by the Addington Hospital.

These adverse conditions made it difficult to treat the patients as humans in such an inhumane environment. There were not enough toilets to accommodate the number of patients in the ward. For example the obstetrics and gynaecology ward had 70 beds but at times it operated at 200% capacity and there were only five toilets for these approximately 140 women.

It was not until the 1990's that the hospitals became integrated and the patients could be transferred to other hospitals that had empty beds. For a long time there were no intensive care units at King Edward VIII Hospital. These facilities were available at Addington hospital which refused to accept Black patients.

Doctors at King Edward VIII Hospital had a problem because whenever they protested there were

difficulties, especially regarding their conditions of service.

Black students were not allowed to train in the White hospitals for example the Addington Hospital. Some doctors felt that their training suffered from the fact that they were forced to do their training and internship at King Edward VIII Hospital. The segregation of hospitals limited their training to one race and they could not get the opportunity to study First World diseases.

Some also felt they did not have the opportunity to use certain types of technology due to the inadequate equipment at King Edward VIII Hospital. Others did not feel that it hampered their training at all. Most of the graduates at the Medical School felt that the overall training was of a very high standard.

At King Edward VIII Hospital there was also very poor accommodation for Black interns that either had to live in or spend the night at the hospital due to long shifts. The accommodation for White interns was separate and superior, the Black students felt that if they complained they would not be given jobs.

Everyone was encouraged to do postgraduate work, however, most of the postgraduate students were White and Indian. Few applicants went on to do postgraduate studies because of financial constraints and because of the perceived lack of upward mobility. Many had to take care of their families or repay loans and thus opted to go into private practice.

The question of inequitable compensation has already been dealt with, but when staff were engaged in protest activity they would receive support from their White colleagues in principle although no concrete action had been taken at that time, and two of the doctors who were leaders in the strike were targeted to be punished by officials. These two doctors were not allowed back into their positions after the strike and interns were told that they had to apologise in writing, otherwise they would be stopped from even getting another position in the country and thus would never be able to practice as a doctor.

Most of the administration of our Medical School including professors and heads of department were White males, especially in the early years of the Medical School. This changed slowly over time as Black medical doctors gained the credentials to fulfil professorial administrative posts. However, there has never been an African appointed to professor or head of department. There has only been one Coloured member appointed as head of department and only two females appointed to this position. Many of the doctors at the Medical School have been frustrated by the lack of role models and implicit glass

sealing that they face in terms of promotion and advancement. Many feel that the Medical School overlooked highly qualified African doctors who left the University of Natal Medical School to become professors at other medical schools, or have been appointed to top levels in government.

In the early 1980's many politically active doctors believed that a black list had been drawn up by the security forces of names of doctors that were too politically active and were therefore a risk to the security of the State. The black list affected doctors in four fundamental ways:

They were prevented from attaining any governmental positions,
they were denied promotions;
many were denied international travel by not being given a passport;
and many could not publish in the scientific press which further hampered the prospects of promotion.

For people who were black-listed the security police tapped their phones, threatened them and their families, raided their homes and offices, held them in detention without reason and even tortured them.

Some faculty members also felt that certain departments were much more difficult for Blacks to get jobs in than in other departments.

The State pathologist said that they were forced to have a security office system. This may have hampered their autonomy of pathologists.

Ethics and human rights patients were treated very badly due to the conditions at the hospital but often this was the only exposure to the patients that the doctors had. So they never learned anything any differently. Respect for patients was not always instilled.

Concerns were also raised that some of the research done on patients at King Edward VIII Hospital was not done in an ethical manner and that the Declaration of Helsinki was not always observed.

Patients were not always properly informed of the risks of the procedure and other options available.

So in summary, culpability, complicity of the University and the Province, both the University and the Province could have done much more. They should not have accepted such conditions for a medical school and its teaching hospital.

Now regarding recommendations which are not in the submission that you have. Mr Chairman we would like to suggest that apartheid was a process of dehumanisation. That it reduced the majority of our people to objects or physical entities. Imperceptibly medicine also became dehumanised. The focus was on the disease and not the person, their family and community. South Africa is politically free, however our people need to be healed spiritually, mentally and physically if we are to create the type of society and country that we all desire. Doctors, medical schools and their teaching staff, and medical students can become important instruments for this change. The most important step in this process is to re-humanise medicine.

Firstly we need to view every person as a whole being. In other words we need to recognise that it is the spirit, mind and body which makes up a human being and that these aspects are intimately interrelated.

Secondly, we need to embrace the concept of health rather than disease. Health should be viewed as a state of perfect spiritual, mental and physical wellbeing, not merely the absence of illness and infirmity.

Thirdly, we need to accept that a person is part of a family, part of society, part of our country and part of the global village, the world. Therefore the state of a person has far-reaching implications which go far beyond the individual.

The medical curriculum has to be changed accordingly. It has to become human centred, in other words, person centred, family centred, community centred.

The social sciences and the humanities need to be introduced and issues such as human rights and ethics covered.

Respect for all people including those of different ethnic backgrounds and respect for all cultures needs to be instilled.

The new graduates should have received training which enables them to have a broader vision so that they can be more socially aware and socially responsible. The new graduates will find it natural to take up issues such as human rights, violence, crime, child abuse, pollution of the environment and global warming irrespective of where in the world these issues may arise because they understand that these issues impact on health.

In short, change is not merely desirable, it is essential. The narrow outlook of the past can no longer be justified.

DR W ORR: Thank you very much Professor Maharaj. I would be grateful if you could put your recommendations in writing and send them to us. I have one follow up question, you have very honestly and openly highlighted a number of problems which affected the University of Natal Medical School. My question is, apart from the reconciliation graduation in 1995, has anything been done to address these issues?

PROF MAHARAJ: The question of trying to redress the issues of the past has been a matter that has bothered many of us especially as being from the past itself, and as we heard from the Wits experience there's a lot of bitterness and unhappiness amongst graduates of colour regarding their position within this institution. As you would have gathered from the submission that apartheid played its own role but the university had decided to add over and above that in terms of how it conducted itself.

Now the position is at present that there are affirmative action and equal opportunity programmes that have been put into place. The question also with regard to selection procedures is there's always a member of the equal opportunities and affirmative action group represented in order to ensure that there is fair play. Clearly not enough has been done. I would say that it would appear right now that what we've done is merely embarked on the beginning of a process. Clearly it is quite evident that much more needs to be done and I hope that our university will actually take the lead in going the full way in trying to restore its position in society and creating a fair and just society. There is still much work to be done if I may say so.

DR W ORR: Thank you, I have no further questions.

CHAIRPERSON: Thank you Professor Maharaj. I would suggest that we break for lunch. I'm sure that all of you are starving. Please come back at two o'clock.

HEARING ADJOURNS

AAAS SUBMISSION

MS MKHIZE: Welcome to this afternoon's session. I would like to invite the representative of AAAS to come forward please.

To both of you, Professor Robert Lawrence and Dr Audrey Chapman I would like to welcome you. It's really a privilege to have you participating in this given your organisation's contribution, not only to this country but within the TRC itself. I will ask the two of you to stand so as to take an oath.

ROBERT LAWRENCE: (sworn states)

AUDREY CHAPMAN: (sworn states)

MS MKHIZE: Dr Wendy Orr will assist you in talking to your submission.

DR WENDY ORR: I want to reiterate our welcome and not only to you but to the rest of your delegation who have travelled all the way from the United States to help us in our work here. We are really very grateful to you and to the other international visitors.

You have sent us a preliminary submission and we have asked you to focus in your presentation on that part of your submission which focuses on district surgeons. The issues, the problems, the potential solutions, so I'd really like you just to move straight into that and we'll then take questions afterwards.

DR A CHAPMAN: Madam Chair, if it's alright what we'd like to do is an introduction that will provide a context for the district surgeons.

First, on behalf of all of the members of the AAAS team I'd like to express appreciation for the invitation of the TRC to participate in these historic hearings. Of the 16 Truth Commissions that have preceded South Africa's Truth and Reconciliation Commission we are not aware that any of them have undertaken a sectoral analysis and we think that this is one of the many contributions that South Africa will have to the process of a country coming to terms with its past.

For the people who don't know what AAAS is, the American Association for the Advancement of Science is the largest federation of scientific, medical and engineering societies in the world. It also has an individual membership of 143,000. For 20 years we have had a human rights programme that has dealt with issues affecting the health, the scientific and the engineering sectors as well as the application of scientific methodologies to the protection and promotion of human rights.

In 1989 the AAAS sponsored a medical mission of inquiry to South Africa that published a report “Apartheid Medicine”, that examined how legal structures in the culture of apartheid denied the majority of South Africans decent medical care and contributed to massive violations by individuals and institutions in the health sector.

The report also examined the role South African professionals played in helping or hindering the promotion of human rights.

When we received the invitation of the TRC, AAAS assembled a consultative team, including the US-based NGO’s, the Physicians for Human Rights, the Committee for Health in Southern Africa, the American Psychiatric Association, the American Public Health Association and the American Nurses Association. Six of the ten members of our team were introduced this morning. I would like to introduce the additional four members. Dr Barbara Nicholls, Miss Diane Kunz, Dr Gregory Bloch and Dr Jack Geiger.

Why has the international community been concerned about violations of human rights in the health sector in South Africa? Health professionals have a particular responsibility to protect and promote human rights, not only because human rights violations have devastating health consequences, but also the protection and promotion of human rights may be the most effective means to providing the conditions for health and well-being.

In South Africa in the past, and I might add in many other countries, a narrow conception of health and ethical responsibilities of health professionals has contributed greatly to silence and inaction in facing the suffering caused by human rights violations.

There is also another reason that international NGOs and academics have been so concerned, and that is that the violations which took place in this country, and which we’ve heard about in great detail in the last two days, have been systematic violations of international human rights standards, and international codes of medical ethics.

Next year will be the 50th anniversary of the Universal Declaration of Human Rights. In the aftermath of the holocaust and the Nuremburg Trials, to which Bishop Tutu alluded at the opening of the hearings, the international community said “never again”, and to that end formulated an international bill of human rights.

Beginning with the Universal Declaration of human rights adopted by the United Nations General Assembly in 1948 the international community has drafted a series of instruments that recognise the inherent dignity and equal and inalienable rights of all members of the human family. The Universal Declaration, broadly considered to be a common standard of achievement for all peoples and nations, enumerates some two dozen specific rights to which all persons are entitled without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Two of the most fundamental protections are the right to life, liberty and security of person and the right to freedom from discrimination.

Other basic civil and political rights that are articulated in freedom from torture and cruel, inhuman or degrading punishment, freedom from arbitrary arrest and detention and the right to a fair trial.

In addition the text of the Universal Declaration sets forth a series of social and economic rights, among them that everyone has a right to a standard of living adequate for the health and well-being of himself and his family including food, clothing, housing, medical care and other social services.

The principles enumerated in the Universal Declaration are further developed in a series of human rights conventions. States which ratified these instruments and thereby become States parties are legally bound by their provisions. Well over 130 countries, including virtually all major nations, have ratified the two most important of the instruments, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.

Our submission goes into some of the specifics of the standards that are in each one of these covenants that provide a framework for the health sector in South Africa. Given the fact that we are running short of time I won't go into that.

But I would like to point out that in 1949, the year after the Universal Declaration was formulated there was, of course, the momentous election in South Africa which set the country on the course of apartheid, which in its very nature violated these fundamental standards.

I think that it's something that we can all celebrate that as we move into the 50th Anniversary of the Universal Declaration of Human Rights, that the political system here has changed fundamentally and symbolically as well as South Africa has begun to ratify the International Conventions. We hope that they

will provide an active set of standards that the new and reformed medical sector will now seek to embody.

PROF R LAWRENCE: I will just briefly address the question you asked us to focus on. In our submission we did have a detailed section about district surgeons that attempt to illustrate some of the problems confronting the health professions under the system of apartheid. Through their inability to resolve the role conflict between duty to their patients and duty to the apartheid state, the district surgeons serve as a prime example of the violation of international law and standards that Audrey has just spoken about, in the discharge of their professional role.

In our written submission we state that while there was considerable variation in district surgeons' attitudes towards their patients, and in the quality of care they provided, district surgeons did, in the main, accommodate themselves to the dehumanising system in which they were operating.

District surgeons commonly participated in abuses by failing to record and investigate apparent signs of abuse by not insisting on appropriate treatment and by not respecting doctor/patient confidentiality. While it appears that district surgeons did not generally participate actively in torture they rarely spoke against inhumane practices. While there were a few bright spots, those few who did speak out against the abuses received little support from their colleagues as we have heard in testimony over the last day and a half, suggesting that the problem here was not restricted to a few bad apples, but in fact did represent a collective professional failure to respond appropriately.

Fundamentally then, district surgeons failed to honour the responsibilities that they had to their detainee patients under, not just international law to which South Africa was not then States party, but even under South African law.

This problem of complicity and torture, or the denial of treatment, the falsification of medical records, the violation of medical neutrality, as we've heard testified to yesterday in which patients were actually seized by security forces while under treatment, all point to this larger picture that we've heard in such graphic detail.

We would like to make three principle recommendations which we will then follow-up in our longer detailed submission later in September.

First, the category of regulation and enforcement. The discipline of physicians in South Africa under apartheid obviously was woefully inadequate and the Council failed to function in any meaningful

way. Based on the testimony submitted yesterday I have to say that I have concern that there is in place the kind of reform at that self-regulatory system that would be necessary to protect against future abuses. I believe that there needs to be a complete restructuring and a recognition that self-regulation has not worked.

The SAMDC needs to be replaced by a pro-active group with representation by progressive community institutions such as women's organisations, labour unions and church groups. What we heard this morning about the changes underway with the Nursing Council, I think provides an example that the physicians group might well look to.

Second, accountability. There needs to be a human rights monitoring body that is both independent and yet empowered to investigate allegations of human rights abuses, including access to patient records.

It is difficult for us, as a group of Americans, to suggest exactly the form that this might take to accommodate to the values and the mores of South Africa, but we do believe that part of a strong, civil society that is now beginning to emerge in South Africa will create a supportive ground for the creation of such an independent monitoring body.

Third, education. Education and health and human rights should be provided at all levels. We've heard others testify to the same concern. Within the health profession schools it must be linked to the examination system in order to assure that human rights education will not be marginalised or trivialised by faculty and students alike.

Re-certification and re-licensure of graduates should include requirements for participation in human rights education and training.

While we applaud the efforts described by MASA to work with the seven South African Medical Schools to develop ethics curricula, we do not believe that this goes far enough. Given the apartheid past and its legacy we believe that education in the areas of social, cultural and economic rights, as well as civil and political rights go above and beyond bio-ethics in the context of the diadic doctor/patient relationship or nurse/patient relationship. It is necessary, in order to understand fully the social determinants of health and disease in South Africa, to appreciate the nature and extent of psychological barriers that might prevent the full disclosure of symptoms and history by patients still wary of the system; to sensitise health

professionals to the origins of the distrust which many patients will continue to feel in months and years to come, and to identify residual, structural impediments to the full guarantee of human rights to the citizens of South Africa, whether patient or health professional.

Thank you.

DR WENDY ORR: Thank you very much, and thank you for being such remarkable timekeepers for yourselves. I think district surgeons demonstrate par excellence the dilemma of the doctor with dual obligations, but obviously they are not the only doctors who have dual obligations. They have obligations towards their patients which you and I believe should be paramount, but they also have obligations to the person or body or institution which is employing them. We see that in the military, we see that in the Police, we see that in the Prison Services. Do you have any thoughts as to how this tension can be addressed, this dual obligation tension?

PROF R LAWRENCE: I believe in the United States we have in our teaching of health professionals focused on the question of values clarification as a way of approaching ethical conflict when somebody confronts a dual loyalty situation. One of the healthy things that I believe would be useful here would be to create regular fora in which people could come, almost like a clinical pathological conference and say in the last week I was faced with the choice to do this or that, I am not sure I made the right choice but this is what I did.

Michael Balant(?), the late British psychiatrist in his classic work, *The doctor, the patient, the illness*, talked about the value of confidential small groups of health workers getting together on a regular basis to share the problems confronting them in practice, ethical, moral, legal problems. A seductive patient, a problem where confidentiality breaches some other kind of family relationship problem, I think here, given the 45 years that you have just been through, that it would not be at all inappropriate to designate a regular opportunity for health workers to come together and to recognise that these are difficult tasks to sort out. People haven't had a lot of experience in dealing with them and then to work that in to the curriculum for health and human rights.

DR WENDY ORR: Thank you. I certainly find that a very useful suggestion. I have no further questions. I certainly look forward to working with you and your organisation in the months to come as we pool our final report and recommendations together, and want to thank you again for coming here today.

MS MKHIZE: I would also like to thank you for being part of this important step in the history of our country where professionals are re-looking at where they are coming from, re-defining their roles as Dr Orr has said. We see you as our allies and hope that you will continue assisting in as much as you can. Thank you very much for coming.

PROF R LAWRENCE: Thank you for having us.

DeNOSA SUBMISSION

MS MKHIZE: We will now be listening to DeNOSA. While they are coming forward I would just like to make a comment which will apply to DeNOSA, NAMDA, OASSA and HHRP, that we will really appreciate it if they try not to repeat what other people have said, especially the work which has been referred to many times, but to highlight those aspects which are unique to their organisations. Thank you very much.

I will ask the two of you to stand up, read out your names so that you can take an oath.

MARY MOLEKO: (sworn states)

SHEILA CLOW: (sworn states)

MS MKHIZE: Thank you. Miss Wildschut will assist you in presenting your submission.

MISS WILDSCHUT: Welcome, may I add my welcome to that of the Chair. I am not quite sure, I am quiet because I am not quite sure what is happening in front of me, so I don't know if this is going to be part of the presentation or - okay alright. Please go ahead and present your submission to us.

MS S CLOW: Thank you, and thank you to the Truth and Reconciliation Commission for the opportunity for us to present.

DeNOSA, the Democratic Nursing Organisation of South Africa was constituted in 1995. At present our top leadership and top management are attending the International Council of Nurses Quadrennial Congress in Vancouver where DeNOSA will be admitted to the ICN and the Commonwealth Nurses Federation, as the organisation representing South African nurses.

It is unfortunate that they cannot be here to make this presentation but this prior commitment was made known to the Health Sector Task Group as soon as the dates were set for these hearings.

Professor Feldun Zimande, Chair of the Joint National Board of DeNOSA and President elect will make introductory comments via a pre-recorded video tape, and thereafter Mrs Mary Moleko and I, members of the Executive Committee of the Joint National Board, will continue the submission on Nursing.

MISS WILDSCHUT: Thank you. I always knew nurses were innovative.

VIDEO SHOWN AND PROFESSOR ZIMANDE ADDRESSES

PROF ZIMANDE: The submission made to the TRC today is a preliminary submission by the Democratic Nursing Organisation of South Africa, DeNOSA, which represents plus/minus 100,000 nurses in South Africa of all categories.

This submission aims to provide background information about the organisation; to provide overall context within which the submissions occur; to outline the parameters of our relations identified at this preliminary stage.

(...indistinct) reflects the personnel and the experiences and perceptions of the (...indistinct). (...indistinct) made today will only provide broad categories and areas whereby (...indistinct) to the rights of nurses were entered.

DeNOSA is a professional and a labour organisation representing more than 100,000 nurses. Organisations that form DeNOSA are TRANA, PNINA(?), SINA, BONA, KNO, (...indistinct), SANA and CONSA.

In November 1996 all these organisations unified thus forming one very strong organisation in South Africa. They thus shared their assets and their membership. The organisation has just gone through the first democratic elections in the country of the nursing profession and the boards that have come out as a result of these elections, that's the national and provincial board, we start operating in July.

For the nurses of South Africa the process of unification and transformation is a major step. It is therefore of great concern that these submissions that have been made today will not harm and destroy the unity that is being developed.

DeNOSA submits that the input of apartheid legislation constituted gross violations to the rights of nurses and nursing in South Africa. In all our submissions that are being made today we cover areas

like violations of human rights of nurses and the nursing profession as a whole; of nurses as women, nurses as men; nurses as health care givers and nurses within the nursing education.

The intention of DeNOSA is to develop and initiate, with assistance of the support from the TRC a reconciliation and a re-correction process that would meaningfully explore and expose past injustices within the nursing profession. Having made these introductory remarks a full submission will be presented shortly.

VIDEO ADDRESS ENDS

MISS WILDSCHUT: Sheila could we ask you to just highlight the aspects of your preliminary presentation because we do know that you are going to give a much fuller presentation later on in writing.

MS S CLOW: At leadership level DeNOSA is committed to engaging with the TRC process as the consequences of the period in question have left severe divisions within the nursing profession that perpetuate distrust, resentment and bitterness.

Nurses have welcomed the opportunity to be heard and want to participate in the process. They are committed to and support a larger participatory and inclusive process that results in individual and group submissions as part of our final report.

To protect the respondents and to encourage participation DeNOSA has secured an undertaking from the South African Interim Nursing Council that nurses making voluntary submissions to the TRC will not be subjected to professional conduct review.

As we have mentioned DeNOSA came into being in 1995. It was the first professional group within the health sector to do so and this was as a result of three years of wide and inclusive negotiations with all groupings of nurses within South Africa. After a further 19 months, in October 1996, unification was achieved with the dissolution or merger of all pre-existing nursing organisations.

The process of negotiation has been a difficult one and in some cases very painful. The current challenge to build unity amongst members, who represent great diversity, is huge. In understanding these dynamics the TRC will appreciate that the energies of the organisation have been largely directed towards issues of transformation, both within the profession and the health sector, as well as holding the first democratic elections of the organisation.

For this reason the submission that has been presented in writing to the TRC, and the oral submis-

sion today, is very much a preliminary submission. The Joint National Board expressed a deep concern that the TRC process should not erode the unity that is being developed. The Board therefore decided that separate submissions from the leaders of the former organisations would be counter-productive to the process of building unity, and so at this stage this submission aims to offer a broad perspective on nursing during the period under review.

We recognise the limitations of the preliminary submission. One of these is that there are many perceptions of the truth in relation to specific issues. But rather than support one perception only we recognise that our history has shaped us in different ways and that we experience and interpret events differently. For that reason we will accommodate these tensions in our submission in an attempt to illuminate our past.

In the final submission that will be made in writing in October greater detail, with careful corroboration of evidence and verification will be included. For example, the roles of the various nursing organisations, and nurses in often side-lined sectors like the mining sector, prisons etc.

As nursing is the one profession which most closely resembles the demographic realities in South Africa in terms of race, socio-economic status and the rural/urban mix, and is the health profession closest to the population, the experiences of nurses in South Africa are a useful indicator of the experiences of the population.

In terms of violation of human rights in nursing DeNOSA submits that the impact of apartheid legislation effected during the period in question constituted gross violations to the rights of nurses and nursing in South Africa. Enacted by officials of the day whose political imperatives resulted in establishing a culture of segregation, discrimination, inequity articulated through acts, emissions and offences, an environment was created and reinforced at all levels of society where severe strife, conflict, untold suffering and injustices were meted to nurses and their patients.

DeNOSA believes that there are many experiences relevant to nurses and nursing that constitute gross violations to the rights of nurses. Further, they have resulted in severe consequences for nurses, nursing and patients at the receiving end of care.

Based on the oral submissions of a number of nurses, violations to their rights as nurses have had serious implications for them in a variety of circumstances, including the right of affiliation as members

of a professional body. These violations permeate all levels of human existence, resonating consequences of a social, political, economic, psychological and in particular, spiritual nature.

The violation of the very essence of human experience, within the context of the spiritual relates to the meaning and purpose nurses attribute to their lives, their sense of worth and dignity and their ability to forgive and apologise.

Unlike the medical profession there have not been high profile cases as we have heard in the last day or so, but as nurses are the backbone of the health sector, as we keep on hearing, it is very unlikely that nurses are not going to be implicated in some of these human rights violations. To this end we have informally requested the Health and Human Rights Project to furnish us with any evidence that relates to nurses so that we can have as full a picture as possible in our final submission.

In the interests of time we do not intend to read our preliminary submission but to highlight certain aspects that have led us to present under specific headings.

MS M MOLEKO: Madam Chair allow me a few minutes to indicate these areas of violation of the rights of nurses.

1. Violation to practice ethically.

This is in relation to theoretical requirements versus enforcement of law and order where nurses are expected to give patients charged to members from the law.

2. Violation of rights to recognition.

Promotion opportunities were scarce. Many nurses retired as juniors.

3. Rights to practice safely. Lack of equipment. Outdated equipment. Lack of professional development opportunities. Overcrowding of patients in the ward. Nursing patients on floor beds. Babies nursed in cots in twos and threes. Staff shortages that have not been attended to over the years.

4. Violation to the rights to provide care. On an occasion a White doctor failed to put up an intravenous drip and left a dehydrated patient who needed the drip urgently. A registered nurse managed to put the drip up and on informing the doctor of this the doctor phoned back and said “pull the damn thing out of that hand”. When the nurse reported to her supervisor the supervisor said let the drip run as fast as you can so that when doctor return

he find the bottle empty.

5. Violation of the rights to decision-making processes.

Nurses and their supervisors find themselves forced to implement policies into which they had no input and to which - which of course they do not support. This leaves them with anger, frustration and a sense of guilt and they remain with this loss of credibility for appearing to have colluded with the unjust system.

6. Violation to the rights to safety and security.

Nurses associated with people of particular ideologies were persecuted for this association. Some of them were ill-treated and forced to leave.

7. Violation to the rights to practice with dignity.

The supervisors, who were mostly White at the time, did not believe that Black registered nurses knew anything. This led to the nurses developing a low self-esteem and self-confidence.

8. Violation to the rights to safeguard the dignity of their patients.

A number of patients, particularly in the mines, an incident is related where males were made to undress and stand naked whilst the doctor examined them for sexually transmitted diseases.

9. The violation of the rights of nurses within education.

Violation of students' rights to equal education. It is a well-known and well-documented fact that our students learn in inadequate facilities. Incidents were cited where students were educated in separate institutions and where Black and White were accommodated in the same building the premises were separated by double doors which were kept closed. Even a communal quadrangle had a six-foot wire fence separating the students from each other. Even though the curriculum is similar at the end of training the South African Nursing Council issues certificates indicating race, and there are individuals who have qualified who have certificates indicating that they were entered into the register for Natives or Bantu and for Black depending on the regulation that was operative at the time.

10. Violation to the rights of tutors to equitable conditions.

This has already been mentioned that conditions are not conducive to learning and to studying and that opportunities for professional development became lesser and lesser for the Blacks.

11. Violation of the rights of nurses to educational advancement.
12. Violation of the rights of nurses to appropriate education.

It is felt that education has to be appropriate to the setting and to the consumers. There isn't enough stress on ethics within a human rights context. There isn't enough stress to culture congruence care.

The next section deals with violation of the rights of nurses as women.

1. Women doing the same work earn less than their male counterparts.
Women were not afforded subsidies and housing loans. A number of women had to divorce their husbands in order to qualify for these loans.
2. Violation of rights of women to maternity leave and reproductive choices.
Women were made to resign as there was no paid maternity leave. It was only late in the nineties that this was made available, even then only for 84 days.

Madam Chair I will hand over to Sheila to continue.

MISS WILDSCHUT: Sheila you have two minutes.

MS S CLOW: The last violation relates to nursing as a profession, and just some of the things where there's been incongruence between legislation and the type of caring and ethical base that one could expect in nursing.

Some of these incongruencies in terms of having to implement legislation has resulted in the formation of Homeland structures; the failure of professional associations and regulatory bodies to investigate inconsistencies in health care provision; the failure of these bodies to represent and defend the interests of Black nurses; the failure of these bodies to provide leadership, guidance and protection for nurses in response to political violence. And then the withdrawal of the South African Nursing Association from the International Council of Nurses in 1973.

In conclusion. We request assistance from the TRC for research support to enable us to complete the final phase of this submission on nursing in South Africa during the period under review. We recog-

nise the need to reflect on the past in order to proceed with planning for the future, and in particular to inform strategies aimed at preventing the recurrence of past irregularities, inconsistencies and injustices.

However, it would be premature to make recommendations for future action and reparation before this particular process is complete, but these recommendations will be forthcoming in the final submission in October.

What is clear is that a fundamental shift in attitude is required, both within nursing and the health sector in general which respects the worth and rights of those both seeking care and those giving care. DeNOSA is committed to being part of that process.

MISS WILDSCHUT: Thank you very much to both of you. I do have quite a few questions which I won't ask now because you have pledged to give us a more complete submission later on this year when you have done some more research and you can give a more complete version of what the status of the Nursing Association was before and how you've moved towards unity.

I cannot resist the temptation to comment about the conversions of events in that the South African Nursing Association, as it was known then, had walked out of ICN, that's one version of the story, and that DeNOSA is now being admitted to ICN. I think that the story of SANA not being in the ICN for such a long time is a story that has to be told and many people do need to know and hear that story, and hopefully that will come into the submission later on.

MS S CLOW: Madam Chair, certainly that will be in our submission. However, Mrs Moleko was at Mexico City when South Africa withdrew from the ICN, perhaps you would like her to comment briefly at this point.

MISS WILDSCHUT: I would have to ask the Chair if we would have that indulgence.

MS MKHIZE: No. I just would like to thank you very much for your presentation, and also to say, as a newly-born organisation, I hope it won't be a change in name, but in terms of policies and practices. Thank you very much for coming.

MS S CLOW: I am sorry there isn't an opportunity to flesh those out now, but they will be in the final submission.

MS M MOLEKO: Our constitution bears witness to our commitment.

MS MKHIZE: Thank you.

NAMDA SUBMISSION

MS MKHIZE: I would like to ask the NAMDA representative to come forward please. Welcome. As I indicated when I invited DeNOSA, I should think this will apply to your organisation as well, we will try to channel you to talk to those areas which haven't been documented. First of all I would like you to stand to take the oath.

MALCOLM BARRY KISTNASAMY: (sworn states)

MS MKHIZE: Can you say your name, your position and where you are located please.

DR B KISTNASAMY: I am Malcom Barry Kistnasamy. I am currently Deputy Director General, Environmental Affairs, Health and Welfare, Northern Cape Provincial Administration. I speak in my personal capacity on behalf of a group of progressive doctors who were part of the executive of NAMDA

between the years 1982 and 1992.

MS MKHIZE: Thank you very much Dr Kistnasamy. What I would like to do is to raise three questions for you so that as you are talking through your document you will have in mind areas which, based on what you have submitted, we felt needed further clarification.

The first question is; how did NAMDA's objectives differ from those of MASA? Where is NAMDA today?

The second question is; looking at the state of health services today are there any strategies learnt from NAMDA, activities which you think would be more effective in ensuring health for all today?

The third question is to request you to spend some time sharing your thoughts on the way forward, especially in view of the fact that up to today survivors of human rights violations are the poorest of our society, and they are from communities where health services are still either non-existent or inappropriate.

Thank you.

DR B KISTNASAMY: Thanks Madam Chair. The National Medical and Dental Association came into being on the 5th of December 1982 at a conference in Durban after more than two years of consultation amongst all progressive doctors, dentists and other health workers nationally and internationally.

In the preamble to its constitution NAMDA proclaimed its acceptance of the World Health Organisation's definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. And perhaps I think that these are things that colleagues within other organisations, both represented here today and over the last two days, probably need to examine in terms of their own submissions in terms of this WHO definition of health.

It reiterated the belief that health is a basic human right which should be available to all the people, irrespective of race, colour, political belief, economic or social condition. It further committed itself to creating the conditions for optimum health which can only exist in a free and democratic society. And I think that's where the variance came in with many of the organisations that saw itself, at that stage, as part of the apartheid State machine, or sharing the world view of White South Africans, and that was earlier alluded to in various things. Whereas NAMDA felt that you cannot have optimum health for people if you did not have the conditions, the structural changes that needed in society to bring about optimum health, and NAMDA committed itself to creating those conditions as well.

Its aims and objectives were as follows:

1. To attain the highest possible level of health for all South Africans.
2. To promote and practice comprehensive health care, emphasising both preventive, curative and rehabilitative health care.
3. To promote the health and allied sciences at all levels of society.
4. To promote and protect the honour and interests of the medical and dental professions, and ensure that every member adheres to the highest ethical code governing the profession. Again we might have deferred with other organisations when it came to these issues.
5. To promote improved standards of teaching in the health, medical and related professions relevant to the needs of the majority of South Africans.

And I think later on when we address the issue of standards we have to ask ourselves what do we mean by standards when we talk about the issues about linking up with the health needs of all South Africans.

6. To affiliate or cooperate with any scientific, professional or other groups which contributed to the advancement of (...indistinct), and this was later to the international context.

And lastly but not the least important;

7. To actively encourage and develop community and workers participation in all matters affecting health care.

Now the background to the formation of NAMDA has gone into quite a bit, suffice to say that the Biko saga and the sad story relating to his death was one of the factors that led to the formation of NAMDA. Let me move on.

Health professionals in South Africa have long been aware of the damaging effects on the health of the population imposed by a system of racial and economic exploitation.

The social consequences of apartheid were so gross, so thoroughly destructible and so widely acknowledged and abhorred by the international community that there could be no avoiding the intrusion into the professional lives of medical men and women in this country. The idiocy of the pencil test for babies, abandoned babies; of floor beds on one side of the hospital while the other half remains empty; Black medical students in ward rounds that ended in the tea room with the porters while the White stu-

dents continued with the White professors to the White side of the hospital; Black nurses that could not have White nurses looking after them, and you heard from DeNOSA and maybe their submission later on will point more to that.

The issues about conferences upon conferences where government policy was acclaimed in terms of the Transkei Medical Association, the Homelands, the League of Nursing Associations of South Africa where SANA and the Transkei Nursing Association, KwaZulu Nursing Organisation came together, where these conferences were to acclaim and loud-hailing the government policy of the day were seen as being part and parcel of delivering health care to the majority.

Now the effects of apartheid and its devastating consequence on the majority of our citizens are well-documented. Suffice to say that it combined class and race to give White South Africans their health care system better than some of the Scandinavian countries, and for Blacks worse than Botswana, a country just north of us.

We need to note that the health planners and the medical superintendents and the heads of departments of health at that stage, we need to note what positions do they occupy today in South African society. These issues of separate casualties, separate waiting rooms, do these health planners still have a role in South African society today.

Thirdly, the formation of NAMDA. With popular resistance rising in the seventies through the eighties the apartheid regime increased repression, even health facilities were not safe, and you've heard of instances of that over the last two days.

There were instances of active collusion by health authorities as with the District Surgeon in Colesberg handing over a patient to the police, to possible participation in biological and chemical warfare. Indeed the doctrine of low intensity warfare had become one of high intensity with deaths, disappearances and detentions being the order of the day leaving us a society deeply traumatised and hopefully this process will bring about healing.

Bishop Tutu himself spoke about Johnny on a submission to a conference in the Frontline States late in the eighties.

“Johnny...”,

writes Archbishop Tutu in his forward to the report of the lawyers committee,

“...is real. He used to be a lively youngster full of life and fun until he fell into the clutches of the security system of the apartheid regime. It is not quite clear what the police did to Johnny, perhaps it does not matter anymore, what is certain he went in a lively, healthy and normal youngster and he came out walking a human vegetable. The police did something to him. It is quite important for the world to know. Johnny is no figment of a feverish imagination. I saw him with my own eyes in Kotze House, Johannesburg”.

These are issues later on when we are talking about handling of children in detention NAMDA campaigned for “free the children”. “Free the children” in terms of not having a code for the handling of children in detention and these are the issues that we are saying we are at variance with counterparts that presented earlier today. You could not have a code for handling children in detention.

Lastly, in terms of NAMDA’s coming into being, was the programme to train health workers for Black, mainly rural areas, by the South African Medical Services, the so-called COMOPS, designed to win the hearts and minds, gather military intelligence or a genuine commitment to the poor? What of the biological and chemical weapons experimentation? Was it merely defensive? The Reverend Frank Chikane’s poisoning, organophosphates, the death of Sipo Mtimkulu. It must be noted that the forensic laboratory’s services up to now still reside with the South African Police Services.

The TRC needs to note that health professionals, not just doctors, but biological scientists, psychologists and others would have had to be part of a wider group providing inputs for the destruction of our people, using their knowledge of human physiology and a psyche. Earlier reports of torture to this Committee and others allude to the use of truth sera(?) being injected to detainees.

Historical perspectives are such that it’s well-documented about the social conditions and the determinants on health and I’m going to leave that out.

Let me go onto, “did we know”? Given what has been documented previously and what the TRC has heard to date, it is amazing that there are not more health professionals coming forward to testify, similar to Sean, and we would hope that the TRC would continue so that more health professionals could come forward.

Ergonomics is a scientific discipline and in its simplest definition looks at designing the work place to suit the worker. Since the earliest days of our mining industry, the backbone of our economy,

heated climatisation chambers were set up to design the worker to the workplace. We need to document what the Chamber of Mines and Wits Physiology Department had done in the early days of designing workers to the workplace.

Recently there has been widespread news coverage of a public health service study in the United States which began in 1932 and continued until 1972 involving 399 Black men who were left untreated for syphilis to let doctors track the course the disease. Madam Chair, our own (...indistinct) continue today. Pneumoconiosis research with volumes of slides of lungs of dead miners in Johannesburg documenting advancing stages of disease, and as yet no interventions. The various drug trials, the people in Lebodi, the rural doctor who spoke about rural health problems, the ex-miners in Prieska, what are we going to do about them and the destruction of family life in terms of migrant labour?

Let me move on, NAMDA's structures. NAMDA was active in all parts of South Africa and enjoyed international support. It grew from 52 members at inception to well over a 1,000 by 1990. I must pay tribute at this meeting to the international aid organisations and governments which provided funding for the organisation's activities aimed at redressing the effects of the apartheid state.

On the other hand the organisations' members were harassed by the State and its structures in various ways. Firstly, inability to get jobs in the public sector. Secondly, harassment by the Security Police.

Thirdly, mysterious break-ins in our offices in Durban and Port Elizabeth and elsewhere with theft of computers and various documents of the organisation including detainee care records, which led us then to devise substantive ways of disguising names of ex-political prisoners and detainees.

Second lastly, detention of members, and lastly bombings and death threats against members. We would like to know who bombed Professor Jerry Kouvadia's house, and that we would ask of the TRC to find that out.

It was unable for us to hold meetings at some of the medical schools, example, Stellenbosch University campus where the students invited us but we could not go onto that campus. The meeting was banned by the Rector, the NAMDA meeting at that stage.

Lastly, we could not get scholarships or research grants, whereas the Medical Research Council continues to contribute to the brain drain of scientists from South Africa by granting scholarships interna-

tionally.

The South African Medical Journal, a reputable health science journal, at one stage devoted an entire supplement, I have a copy of it here, attacking Dr Emjee(?), a former president of the organisation. A similar article attacking NAMDA dental colleagues appeared in the Dental Association South Africa's journal. We heard of earlier submissions where the journal refused to tackle what they call "academic valued articles", and peer review (...indistinct) articles, and we would like to know what is the peer review of this article in terms of it being there in the supplement of the SAMJ, 18th of July 1987.

At a branch meeting of the Medical Association of South Africa in the Western Cape in 1987 an Army Intelligence officer addressed that meeting about NAMDA.

Where is the organisation today? Unfortunately the Association finally merged with other progressive organisations in 1992 to form SAHSO, South African Health and Social Services Organisation. Since 1995 a core group of ex-NAMDA doctors have rallied around the umbrella of the Progressive Doctors Group to begin discussions about a united medical association for South Africa that will espouse the true values of health and human rights.

Very briefly NAMDA's programmes, and this might have an impact in terms of the future function of the TRC and the health sector in general. There were major health policy initiatives by NAMDA that are now coming to bear within the Department of Health's formulation of health policy and we are glad to say that NAMDA's earliest contributions have contributed in more ways than one to a national health system for South Africa, a new system of medical education and training for the health sciences, and lastly debates on health financing. Those policy options are now firmly entrenched within the South African Government's programme of action.

Secondly, care of ex-political prisoners and ex-detainees and their families. You heard yesterday testimony from one of our colleagues in Livingstone Hospital, of NAMDA's inputs that were made together with other progressive organisations. We had made submissions to structures such as the Department of Health at that stage, the Medical and Dental Council, from example, the Fort Glamorgan issues in the East London area, the Eastern Cape, however to no avail. We would like to know where those documents are today and whether there would be a re-opening of some of that evidence.

In addition the State very soon after NAMDA safeguarding hospitals in the eighties began to

move ex-detainees to No.1 Military Hospital. What was different from public sector doctors, so-called NAMDA doctors treating people in public hospitals than military doctors in no.1 Military Hospital? There were quite a few ex-detainees, the detainees that were moved to the Military Hospital.

Lastly there were psychiatrists as you heard today that began to justify detention and justify torture and I think those issues need to be examined further. To the extent that NAMDA began to say that we were treating not post-traumatic stress syndrome, that we were treating continuous traumatic stress syndrome.

First aid training. This programme began as a direct result of the violence in the townships and the many mass rallies that were being held. Many wounded people were arrested in hospitals and thus were afraid to go into health facilities. Examples abound where security forces surrounded health facilities or set up mobile police stations outside health facilities. In addition health facilities were at times closed during periods of unrest.

At that stage Madam Chair, organisations such as St Johns, the South African Red Cross and Noordekulp like were, according to our perspectives, not responding adequately to the needs of the victims of security force action. They were still continuing with life-saving activities and old age homes. Content of the training which NAMDA developed was aimed at community based organisations and trade unions and focused on first aid, emergency medical supplies, counselling skills and organisational skills to meet urgent health needs.

NAMDA members and other progressive health workers were asked to ensure the safety of all patients at health facilities and provide care for the victims of violence, and yesterday was quite an emotional outbreak in terms of Dr Pat Naidoo and other colleagues like Betty at Livingstone Hospital.

Of special note was an attempt by NAMDA during the latter half of 1985 and early 1986 to get information on the nature of the compound used in teargas. We needed to know what was in teargas and how to treat it because there were instances coming through of media reports attributing deaths and severe ill health to the indiscriminate use of teargas. This information was denied to the organisation.

The next programme was a progressive primary health care network which was launched in 1987 and still remains to today in terms of a highly major grouping of community based organisations and health workers contextualising the political, economic and social conditions which give rise to ill health, and that structure continues to this day.

It emphasised community accountability, comprehensive health care and ensure that health workers use their knowledge and skills to service the needs of the disadvantaged.

We further went on to have a national campaign on apartheid in health de facto in 1987 this was launched. The campaign had four objectives, to publicise the fact that hospitals were segregated by race; to enable Black patients to be seen at White hospitals; to de facto integrate hospital inpatient facilities and to force government to publicly declare that all facilities are open to all races. International campaigns that NAMDA engaged in was against torture, detention and racial segregation of facilities for the isolation of health professionals in South Africa, especially the Medical Association, the Dental Association, SANA and such structures, government functionaries and academics. And particularly when it came to academics who held a fairly liberal view of individual rights versus group rights, and they felt that this was curbing their international linkages. And unfortunately there are many of them present here today in the audience who still feel that this was a major impact in terms of their own growth, whereas the needs of the majority of the South Africa's citizens were being denied at the same time.

Lastly, NAMDA campaigned for the release of political prisoners who had health problems.

We did publish articles that were not covered in this SAMJ but were covered in prestigious journals like the BMJ, The Lancet and such international journals.

The very special programmes that we worked with, there were local programmes like "Free the Children Rights" campaigns, etc, and I must say, in conclusion, that all the other programmes while initiated by NAMDA had close collaboration with the Health Workers Association, which later became the South African Health Workers Congress, the Detainees Parents Support Committee; the Organisation for appropriate Social Services in South Africa; the South African Council of Churches and various doctor and dental guilds.

Some thoughts on the way forward. Human rights as a discipline becomes part of the curricula in our education system, and the patient's charter of rights needs to be emphasised. However, we should be wary that the custodians of this human rights culture are not the very perpetrators who benefited from a system in the past. I find it almost impossible where we find chairs of human rights or whatever ethics that are still held by people from the old establishment. We need to see about people who were actually denied fundamental human rights taking up those chairs and those professorial posts.

The annual NAMDA human rights lecture, we had a human rights lecture series be resuscitated in conjunction with the Human Rights Commission and we feel this would be a token to NAMDA and the work that it did in those dark years in terms of the human rights lecture series being resuscitated, where we would then work with local people, the African experience and further experiences in South America where I think those things need to be probed as well, the links in terms of South America and various countries like Uruguay, Argentina etc, and the South African Government and its agencies in those dark ages of the seventies and the eighties.

Thirdly, very important to the future function of the TRC and its recommendations. Many of the survivors of the high intensity conflict need health care, especially counselling services, and it's nice to know that Project Curamus is there for ex-servicemen and servicewomen, what about a Project Curamus for the victims and the survivors of apartheid's human rights violations? One of our own workers who over 20 years worked in the human rights field has currently had major psychological problems and he doesn't have an Operation Curamus to help him. Can we get the SANDF to assist us further in this field, together with the Department of Health. Let's extend their services.

Fourthly, we need a much closer examination of the role of the district surgeons. They are still present today. And the delivery of health care to prisoners and victims of State-sponsored violence. Perhaps we should note that many part-time district surgeons also have those separate segregated facilities. How many of them are members of current organisations such as MASA? Should we not be taking them to court, Constitutional and other ways, but apart from the fact of saying part of the conditions of service with Government as district surgeons that you cannot have separate entrances and separate facilities?

Fifthly, as with the landmines campaign which we applaud the South African Government for taking the lead on, we should begin a campaign against biological and chemical weapons, in fact campaign for peace and promote a war against poverty. That's the biggest threat to this country, poverty.

The TRC further needs to explore the relationship, if any, between military regimes, especially in South America and the brutal methods of torture and violation of human rights that took place in our country all these years, in line with biological and chemical weapons offensive.

Six, seven and eight, in terms of its recommendations the various organisations, Medical and

Dental Council, Pharmacy Board etc needs to examine their own rules and that they have started to do. The professional organisations MASA, DASA, the Optometry Society, the Occupational Therapy Society, there's a whole range of these bodies across the range in South Africa and I don't think the TRC hearings have concentrated enough in terms of beyond doctors and nurses and psychologists. Many other health professionals helped in some ways or the other to uphold the apartheid state. They need to examine their roles.

The voluntary organisations, the Red Cross, St Johns, Noordekulp like, consider their role in terms of the international charters that they were part of, and what were they doing and what are they going to do.

Lastly, I am part of the Department of Health, and I spoke in my personal capacity, I hope that through my own involvement in the Department of Health we will continue to make changes, with government involvement, with political inputs, to make changes that satisfy the aspirations in terms of the health needs of all South Africans.

In conclusion the wounds and the scars remain, memories of a continuing past which will not disappear. We are only beginning to set the economic and social foundations for a health system that meets the needs of all South Africa. Medical ethics in times of armed conflict are identical to medical ethics in times of peace. The World Medical Association quotes that the supreme guide of the doctor is his conscience. How many of us have been true to our conscience?

I thank the TRC on behalf of NAMDA and its colleagues for allowing us to make this submission and we will continue to work with yourselves in whatever forms to actually take this process forward in terms of the reparation process thereafter. Thank you very much.

MS MKHIZE: Dr Kistnasamy thank you very much for representing what I will say, all the survivors of human rights violations as well. Dr Rateman shared about what he was exposed to as a student in the South African universities, so I see you certainly as one of the survivors who remain a strong voice for many people of South Africa who have suffered under the previous socio-political order.

You have made a commitment to work with us in finalising some of these ideas and we will continue to pose questions to you, especially as we finalise our report. Thank you very much for coming forward.

MS GOBODO-MADIKIZELA: Excuse me. While you are on your way out, can you tell us about this organisation that supports ex-servicemen?

DR B KISTNASAMY: That was part of the SAMS submission.

MS GOBODO-MADIKIZELA: Oh okay.

DR B KISTNASAMY: And what we are saying is to extend that to all South Africans.

MS GOBODO-MADIKIZELA: Okay, thank you.

MS MKHIZE: Maybe just while you are leaving I would like to mention one thing, that we have received submissions from the Physiotherapy Board, Occupational Therapy Board, South African Pharmacy Council, Medical Research Council, HSRC, so we are working with all these other bodies.

OASSSA SUBMISSION

I will then invite a representative of OASSSA, Miss Ann Harper to come forward please. Thank you very much for coming forward, Dr Orr will assist you to take your oath.

DR WENDY ORR: Ann welcome. I know you've travelled all the way from Durban to be with us and we are very happy to have you here.

ANN HARPER: (sworn states)

MS MKHIZE: Welcome again. I will try to do the same. I will pose three questions to you and ask to talk to those aspects of your submission which will address the three questions.

Your organisation operated during a difficult period of extreme political oppression and I am almost certain that you experienced difficulties related to the type of work you were doing. A specific question,

1. What specific problems and impediments did you have to deal with in relation to service with special reference to:
 1. The type of people you were counselling and their conditions;
 - Counselling as a professional service;
 - Your role as professional counsellors.

I know counselling wasn't the only objective, it was providing health care as a whole.

The second question is,

2. To a certain extent some mental health professionals, psychologists, psychiatrists, medics, nurses, as well as some professional bodies are reported to have either colluded with the State or maintained an uneasy neutrality, do you have any experiences that should support this belief or observation?

If so please if you can just talk to those sections of your submission.

3. Such violations of human rights should never have happen again, that's what virtually all the people are saying, what suggestions do you have to prevent non-repetition of such acts?

Thank you very much.

MS A HARPER: Thank you very much, and thanks for the opportunity to present something in a more structured form than the previous submission we made to the TRC. It was certainly at their nudging that we were encouraged to try and put down some of our thoughts into a more structured format.

I perhaps need to explain that I am certainly not speaking here as OASSSA, the organisation, in case some of my colleagues in the audience think I have forgotten organisational discipline, I actually am speaking as the Durban Branch of OASSSA, and more specifically the Detainee and Repression Counselling group.

So if I could preface my input to say that this was drawn together by the remnants of that group who have spent time together trying to reflect on the experiences we've been through which in fact we

discovered had pre-dated OASSSA days.

And perhaps if I could just try and follow the order of your questions and structure my input by saying that there are two specific events, although obviously all the issues that have been raised over the two days informed the response of the organisation and of this particular group. I think two in particular are linked to the roots of this particular group of counsellors. The one was the mass detentions in the 1980's, and as a result of that, and one of the many responses was the formation of the Descoms, the Detainee Parent Support Committees, and those committees, very quickly, as their work increased, started to pull in legal, medical, psychological, welfare sub-groupings into the Descom structures, and a number of the people who were part of this counselling group had their origins there. So it goes right back to those days.

What happened after that was the need to organise perhaps more coherently the work of the psychologists, the social workers, the people who were coming at the detainee work from a mental health or health perspective, and the Natal health group was formed in support of the Descom work. As that developed more and more we found we were drawing in physiotherapists and doctors, students, and I need to give enormous recognition of the role that students played in the work that we did, they certainly nudged the professionals into moving faster.

As this was going on in the Durban region OASSSA was forming itself in the Transvaal, and that was in the 1984/85, so that in the Durban region there wasn't really a need, it wasn't perceived to be a need for us to, at that stage, form an OASSSA branch.

The next major event I think that shifted the focus of what we were doing to some extent, and also deepened the work was the state of emergency. That the health care systems and the social service systems of that time were inaccessible as it was were fragmented, were certainly not near to where the need most was. And what became apparent to us is that we had to have a response to that lack of accessibility.

So from the Natal Health Group a new group formed called the Emergency Services Group which worked together with the NAMDA people and a number of organisations that my previous colleague articulated. So we had a history, if you like, of development, the two main political events that happened, one was the mass detentions and the need to have a response to that from the mental health sector, and finally the state of emergency which really made accessibility to any kind of care and support almost

impossible for the people who most needed it.

I had included here some background on OASSSA, but perhaps if I could throw it out as a challenge to executive members of OASSSA, the need to really write their history and to put together in fact the origins of that organisation as a whole because I cannot hope to do justice to all the areas of work which were included in that organisation's brief.

If I could just touch on the headings of what OASSSA was attempting to do at that time. By 1989 there was a branch in the Transvaal which had started in '83, Cape Town '85, Durban '87 and 'Maritzburg '87 and Grahamstown in 1989, so by that time OASSSA was well launched. It's general brief and terms of reference, because one has to, and I think, I don't want to belabour the point it's been made very well in the last two days, that the mental health services, the practice, the training, the professions, the professional bodies in particular were very closely reflective of the wider society, the divisions, the fabric of the apartheid society certainly was reflected within everything that - all those areas of psychological life.

What OASSSA then tried to do, and I'll talk a bit about, I think the origin in the Transvaal as quite a symbolic beginning for the kind of people who were drawn to OASSSA was, the group of ad hoc students who got together in about 1984 to protest the location of an Institute of Family Therapy conference on the family to be held in Sun City, and I think that that was quite a significant turning point for many people because the total obscenity of holding a conference that was going to be focusing on family life in a homeland where, and in the context of a system which is actually destroying families, did not seem to perturb the organisers of the conference, but it certainly motivated a group of students of the time to say there is something terribly wrong with this type of process. So I think that was the kind of - then there were moments like that in psychologists lives I think where suddenly having seen South Africa a different it was impossible to say you did not know or you had not thought about it.

So what OASSSA tried to do really was look at how the Mental Health and Social Service workers were organised and to try, I suppose, in many ways provide an alternate home for the psychologists and social workers. We had a number -we were quite open membership who just did not feel that they fitted into the traditional professional bodies. So it did have an organisational aspect to it.

It also attempted to research and expose the social, economic and political conditions which we believed undermined the wellbeing of all the people of South Africa, and I don't want to go into that

because I think it's very well covered. We certainly are willing to put a more detailed report together to list those.

Also to develop and try and offer more appropriate social service which was much more responsive to the real needs of the society as we saw them and based more in the realities of the people who were most disadvantaged in terms of access to the few and fragmented services that were available. So we also wanted to challenge the way we went about our work. In fact it was reinforced today, the training of psychologists was happening in this extraordinary vacuum, it certainly wasn't happening in South Africa and you learnt nothing in that training about the realities of the difficulties that the majority of our citizens were facing and the threats to their actual wellbeing. So we felt it was necessary for us to start examining what we were doing to try and find different models of doing our work.

Another part of that was to try and share our skills. The South African psychologists were very elite, maybe, I am not sure about past tense, but there is very much a sense of "expertise" and you do not work with non-professionals. You do not share your case notes with social workers at one stage. So we were trying very hard to share our skills as much as we could wherever there were people who were already identified as care-givers in the community.

So the counselling group in particular, perhaps I need to focus for the rest of the time very quickly on them, the counselling group, the detainee counselling group then which was a subset of the OASSSA were specifically counselling ex-detainees, their families and their friends. I think the point has been made that the State was certainly not just targeting individuals, they were targeting the whole social network and support system of people who were detained.

And as our work developed we found ourselves more and more working with victims of various forms of oppression and repression and violence as well. I will go into that in a bit more detail. Police and vigilante harassment especially in KwaZulu, compulsory conscription, we found more and more that as we became identified as a resource within the community this very small group of health care professionals and workers were being called upon to intervene or become involved in the care of a number of different people, although as I said we did start out as a detainee family and friends group. The work with the detainees, as Barry has mentioned, was carried out very much with NAMDA under the auspices of the emergency services group.

The other work that we felt it was important to get involved with was just presenting workshops and seminars and talks on detention and the effects of detention, because at that stage we felt it was really necessary to try and counter the denial of State officials that in fact torture and abuse of detainees was really taking place. And if you remember the state of emergencies there is no way that you could get that information published. You remember the Weekly Mail where they eventually published just one blank page because everything was banned and censored at that time. So we felt it was really necessary to keep running workshops, keep trying to tell people about what was going on. And again we need to give credit to the overseas supporters who enabled us to publicise some of that work.

It also arose the need for workshops to try and broaden the net of support in the townships because it became impossible for us to hope to get our services into the townships. If there were services in the first place people just did not - were not able to enter or leave the townships and the people who were in there we found were enormously resourceful, the ministers, the teachers, the grandmothers in particular, the mothers, were very much seen as the support system within the townships, and we felt it was much more worthwhile for us to train other people who might be able to offer the support at source, if you like.

We were also involved in a number of other activities which I will elaborate in a more detailed submission. But perhaps if I could go on because I think it is a slightly different stance that I would like to present here about the way in which being a professional psychologist, or a group of professional psychologists who were trying to do things differently, or work with people who were seen to be enemies of the State, the way in which that actually was made more difficult by our professional organisations, the lack of support from colleagues, also the way in which it compromised the kind of service we could offer to people. So I'd like to spend a bit of time on that and avoid the repetition of the other inputs.

The most frequent groups we saw, as I had mentioned earlier, apart from the ex-detainees, were people, activists who anticipated being detained or becoming victims of violence, and in KwaZulu that was quite a significant group. That created a very particular challenge for the psychologists, because when you were working with people on the run the assumption that you would be seeing people for a number of sessions, or you would see them in a location which was clearly identified was totally thrown out the window. You had to become a person who would go to where people were in hiding, and that usually involved a whole network of moving around. At that time that was not an exercise without its own

dangers.

Another group that started coming to us much more were the conscripts, so they were people who were attempting to avoid the call-up, people who are AWOL and on the run, or those who had completed their military service and were totally traumatised by their experience. I found that group escalated, especially during the state of emergency, in terms of the students on the campuses.

The other groups which, and in our more detailed submission we will go into the kind of issues that we were forced with, were ex-political prisoners, returning exiles and I think it's a group that still needs some thought. And in KwaZulu in particular, displaced children, children who were trying to escape the violence, particularly of the Midlands and Pietermaritzburg and we found this huge wave of street children who suddenly entered the city of Durban.

From a counselling - another obstacle was just the profession itself, I don't want to go into that too much because I think Lionel captured it very well this morning, but basically the PASA - although we had made attempts to try and get them to take a public stand against apartheid and to actually come out in recognition of a link between apartheid and the enormous damage that it was doing to the people in the country, both PASA and the Society for Student Counselling refused to do that. Eventually, I think after two years, they came out with very watered-down versions.

So we were operating without a base, if you like, without the support of our professional body. I think it was mentioned this morning, they hid behind the professional neutrality or objectivity, and in fact their silence and inaction of the majority of the health professionals possibly, became a way of colluding with what the State was trying to impose at that time.

It is more than possible that collusion took more of an active form and I think a lot of people have alluded to that, and one encourages the TRC to try and investigate that. We will certainly cooperate in whichever way we can.

You also asked me about our role as professional counsellors, and I'll try very quickly to cover what we thought as the ways in which our own professionalism had been compromised. And even started questioning the quality of the care that we were able to give to people. It became an issue of your political credibility actually outweighing your credibility as a good psychologist or a good counsellor because of the way in which we were having to offer our services. We were often seeing people in inadequate

facilities because you couldn't see people in the clinics because the State services or a lot of the places where you might have been able to operate were viewed with suspicion, especially by the people on the run, and there were certain buildings which were being watched. So where we ended up seeing people were often odd ad hoc rooms with no sound proofing, not conducive to counselling at all.

The whole issue of confidentiality and record-keeping I think Barry covered it very well, became an enormous issue where it was important for the people we were seeing that nothing was written down and we had to go through all sorts of manoeuvres to try and disguise what we were having to record, but certainly in terms of professional behaviour and ethics, the fact that we didn't keep records and we did not make those available to anyone could have become an issue. The lack of continuity, you could not assume that you would be able to see people in a follow-up or referral situation. The referrals were impossible. You had to rely on the network of people who you were working with and the network organisations to do those referrals. So again as a professional you were compromised, you were seeing people quite often one off, and you had to try and do what you could within that time.

Another moral and ethical dilemma and I won't cover the other points that we did raise, was that you needed to maintain your credibility as a profession so that your word was treated with seriousness, but at the same time in doing that you were put into a moral dilemma. I'll give you an example of having to assess the mental status of conscripts knowing full well that if they were not sick enough they would be forced into a situation which they found totally abhorrent, so you were all the time - your own professional standards were being challenged by the moral consequences of what you were being faced with at the time.

Also just to mention that it was a very, very small group of people, so the pool of people you could draw on, because you were not getting the support of your professional bodies, it was a very small group of people who were engaged in this work and that put enormous strain on a very small group who were having to face quite seriously traumatised people, be they detainees, torture victims, be they conscripts.

So I think if I can in a very rushed way, knowing your time constraints, if I can just move on to some of the recommendations we had in mind and make a commitment to put this into some sort-of form, a report that would stand more substantially on its own.

Our recommendations for the TRC I think really just underline and reinforce recommendations

that have been coming from some of the submissions today, that adequate allocation of resources for the provision of mental health and community care to those still traumatised by the violence, oppression and human rights abuses of the past, and I think it's been emphasised by others as well, and those who are experiencing ongoing violence, I think there is an assumption that all is well. Certainly in KwaZulu this is an ongoing need and certainly the facilities are not there. It's the same people quite often who didn't provide facilities and services before who are still the people in charge of the services if they are there.

That, in our opinion needs to include ongoing and systematic support for those people who have been encouraged to tell their stories at the TRC. There is a worry from our side, I think coming from our experience of working with people who you are encouraging to talk about their traumatic experiences, that that trauma is a very ongoing, has very ongoing consequences, and although there's a feeling of relief at having spoken about things I guess it's a plea to the TRC to ensure that their support is an ongoing and structured one for those people who might be telling their stories for the first time.

A group, as we were talking, our little detainee counselling group, a group that we never thought we would want to focus on as much as it's becoming more apparent to us, that young boys of 18, 19 were forced into compulsory brutal military training. They were deployed inside and outside the borders, often forced to commit the most dreadful acts, and for them only to discover, in the light of the new political dispensation and public revelations that the rationale for their behaviour and the framing of their experiences was being manipulated by politicians and securocrats and I think we are not even touching what is going on with that group of young people. I am not talking about permanent force people, or people who made a choice, I am actually talking about those people who were forced at a very young age to commit some of the most vile acts.

I think the plea to the TRC would be to recommend that all avenues be explored to enable these young people to tell their stories be given a sympathetic hearing and obtain professional assistance.

The final suggestion, if you like, because we battled to know quite what it was that you were asking, was to have some sort of public - we couldn't decide if it should be a protector or ombudsperson or a monitor for human rights as they pertain to the health sector. I think a couple of presentations today have underlined that as well. And they need to include in their brief and monitoring of the consequences of human rights abuses from the perspective of the health sector, and especially the mental health, because

quite often mental health is put very low on the list of needs, mental health and community care actually, to monitor whether the professional bodies do actually fulfil their commitment to change, their model and their training, their models, the behaviour, if you like, of their members. We would take a guess, without hoping to be too cynical about it, that self-regulation of the profession and the health sector just hasn't worked in the past.

So it feels like there needs to be an outside agency that is monitoring that, and we have got a number of examples of the kind of things we feel would need ongoing monitoring, even in a society which is perceived to be a democratic one.

I think then, just in conclusion and I am sorry that I've gone over, is that I think an awareness that came to us as we talked about our experiences that changing the distribution of the political and economic power will not automatically change the nature, accessibility, training models availability if you like of mental and community health services. It actually has to have a push, something needs to push that to make it happen, and I think we are hoping that the TRC sees itself as having an on-going responsibility in giving further impetus to the kind of commitments we have been hearing today. Thank you.

MS MKHIZE: And thank you very much for coming forward. We are hoping to get that submission from you as soon as it is ready. We thank you very much for agreeing to participate in this process. Thank you.

While HHRP representatives are coming forward, Dr Orr has got one announcement to make.

DR WENDY ORR: We announced this morning that copies of submissions were available from the Quick Copy Centre in St George's Mall, unfortunately, I don't know if this is sabotage or mere coincidence, every single machine in the Quick Copy centre has broken down, so that arrangement no longer pertains. We are trying to come up with some sort-of alternative. For those of you who are leaving today if you can give us your names and address we will undertake to get the submissions to you, otherwise if you are going to be around for the next few days we will try and find another copy centre where the machines are working. So please don't go to Quick Copy looking for submissions. Thank you.

HHRP SUBMISSION

MS MKHIZE: Dr London in welcoming you I would like to make the same plea, that we will really appreciate it if you can limit your presentations to those aspects which haven't been heard, and Ms Wildschut will assist you to take an oath and then Ms Gobodo-Madikizela will assist you with your submission.

LESLIE LONDON: (affirms)

MS GOBODO-MADIKIZELA: Thank you Chairperson and welcome again Leslie. You have submitted a 200 page document and it's very succinct and I just don't know what to say to ask you to - whether to ask you to speak on certain parts, but I really leave that up to yourself to decide which parts you think we should hear in public today. Over to you Leslie.

DRL LONDON: Thank you Pumla, thank you Commissioners. The document is now down to about 10 pages so I am sure we will fit into the time allocation.

This submission is on behalf of the Health and Human Rights Project, which is a joint initiative of the Trauma Centre for Victims of Violence and Torture, and the Department of Community Health at the University of Cape Town. In developing this submission the Project has drawn on the experiences of a wide range of human rights activists who have been active in the field of detainee work and support for victims of repression over the past years, both in Cape Town and nationally and we want to acknowledge their contribution.

One of the Project's key aims is to facilitate the process of documenting past involvement of health professionals and their organisations in human rights abuses so as to prevent recurrence in the future and to develop guidelines for how to operationalise that.

The Project operates with the premise that the health professions and society cannot afford to ignore the past, and that the cost of this selective amnesia which we see so much of with regard to past human rights abuses are enormous. It is very difficult to see how any trust, within the health sector and also between the health professionals and the broader community can be achieved until the truth is disclosed.

We believe that only by fully acknowledging and understanding what took place in the professions under apartheid is it possible to achieve reconciliation in the health sector. Any apologies that are

made without this understanding will fail to achieve meaningful progress in moving the health sector to a human rights culture.

And while the TRC has played an important role in stimulating this process the real challenge that faces the health sector is for health professions to accept human rights as a fundamental responsibility. Real truth and reconciliation can only come from below, from within our institutions and should be seen as part of a larger project to rehabilitate the health sector and build a culture of human rights within it.

After those comments I just want to digress a little bit and particularly for the benefit of the lawyers who've trooped into this hearing, I think we, as the Project, want to register our concern for this whole process which has led to a situation where many of the cases that we have brought to the attention of the Truth Commission we cannot actually name the particular health professionals involved. We are not going to name those health professionals but we feel it is really a travesty of the process of truth to arrive at a situation where we cannot speak openly. We fought for many years for a situation where people will be free to speak the truth and it seems that legal mechanisms have been invoked to limit the extent to which the truth could be disclosed. We would like the TRC to take note of that, particularly the fact that as far as the Project was concerned we were able to supply the TRC with the names of the doctors as far as we understand within the required time.

Just in that regard we can talk about the kinds of cases we would have discussed. These cases would have included, for instance, the poisoning of political activists, the development of chemical warfare capacities for the SADF; the failure to adequately explain the death in detention of Mr Sipo Mutsi, who police claim suffered an epileptic fit and fell backward in a chair resulting in his death; the cooperation of a health professional in the torture of an ANC cadre captured in Messina in 1987 by ensuring that the detainee could survive further interrogation and assaults; a case where there was a failure to report injuries sustained by the detainee Jonas Cheshum Moataung in Johannesburg in 1980, and a host of other cases. We won't name those.

What we do cover in our submission is issues of looking at complicity of health professionals in prison and police cells and that's been extensively covered.

We also raise issues around military health personnel and we particularly want to challenge the SAMS whose presentation yesterday did not touch on any of the issues that we've raised and I think

Commissioner Ramashala has certainly posed the question to them, but we have presented evidence regarding programmes which involved the re-programming, the use of aversion therapy for gay men in the military and we believe that these cases require further investigation, and the TRC, we would hope, would follow up in that regard.

Forensic services have been covered in some detail. We want to add to the list of cases raised the question of organ harvesting and the way in which practices in which organs were harvested appear to have been substantially racist in the past and has violated the rights of Black families in the way in which shortcuts were taken towards achieving consent for the harvesting of organs.

In terms of hospitals we've heard quite extensively from the Eastern Cape, and from Mark Bletcher and from others about the way in which hospitals were turned into arms of the security establishment. I won't go into that in detail, but just to say what is of real concern is that even though the environment has changed and we don't have detainees or injured people arriving at hospitals we do believe the mindset of the hospital administrations has not changed, and I'd like to hand this in to the Commission. It's a memorandum which was released by the Groote Schuur Hospital region as a hospital notice 12.97 dated 14 May 1997. This memorandum deals with admission and treatment of foreign patients and it's really about questions of how the hospital should deal with patients who are foreign. And point 2 under "Policy", he talks about

".....refugees and illegal immigrants, i.e. people with no temporary residence document. They may not be accepted as patients unless as in an emergency and their presence should immediately be reported to the nearest South African Police Service office or the Immigration Department by admin reception staff".

What this means to us is that the thinking in the health services has not changed. Ten years ago it was detainees, it was people injured in gunshot injuries, today it is another form of social deviant, it's the illegal immigrant without papers.

We make these points because we believe that even though the health sector at a micro level was complicit in abuses, these were not isolated, these were not events involving a few bad apples, as the term has already been used, rather these abuses arose in a context in which the entire fabric of the health sector was permeated by apartheid and in which human rights were profoundly devalued.

We have heard much about the training institutions, and we would support the notion that by the internalisation of apartheid policies and the way they treated Black students and Black patients the health training institutions created the environment where professionals would qualify and be more amenable to the bending of professional ethics to suit the exigencies of security force priorities.

We want to also state that the lack of attention to ethics in human rights in undergraduate and postgraduate curricula, notwithstanding all the words said today, has changed very little since apartheid days. And particularly that there is a substantial difference between human rights and ethics and the institutions need to consider this in their developments.

Underpinning this also was a form of medical science that was devoid of considerations of the implications of human rights for the health professions. Under apartheid we saw a scientific discourse that justified the use of racist terminology and that promoted a research agenda that harmonised with the needs of apartheid. Scientific data were misused or neglected to support apartheid policy objectives and we give various examples of that.

Where research findings did present a different view of reality the authorities and hallowed research institutions, such as the Medical Research Council, in medical journals in State departments wasted little time in suppressing this research. And in particular there's an extensive and very well researched documentation included in our submission of the work by George Ellison and Theo de Wet on material published in the South African Medical Journal over the period 1950 to 1990 which reflected how scientific papers, how editorial policies' letters reflected and reinforced discriminatory policies in the country at the time.

We've also examined the impact of State policies and we won't go into that in much detail.

We also want to make the point that health administrators and civil servants under apartheid had considerable leeway as to how vigorously they operationalised the grand plan of apartheid and at what cost to individuals. I'd like to quote, this is correspondence from the Minister, it's quoted in Federal Council Minutes in the South African Medical Journal and is in relation to correspondence where the Medical Association wrote to the Minister in connection with the question of Black doctors in hospitals. At that time Black doctors were effectively being precluded from working in hospitals because they were not allowed to give orders to White nurses. The Minister's response to the MASA is the following, and

the translation from Afrikaans is mine so you must bear with me.

“On the first aspect, in other words the question of the patient choosing the doctor, the State has controls because the State provides the facilities and equipment for the treatment of the patients. For reasons, that are not to be discussed now, the government’s policy states that separate facilities will be provided for different race groups in so far as practical. The general policy permits the provision of facilities and equipment for such patients, in others words White patients who were going to be treated by Black doctors at public hospitals, only, where in the opinion of the hospital authorities, it is practically feasible”.

And this is the point, the Minister goes on to argue,

“I am not aware of the norms applied by directors of hospital services and because the Minister and the Department have no control over the way the Provinces apply their practices within the overall national policy. I unfortunately cannot give any information as to whether the directors apply their policies in a uniform manner”.

We believe this means that the directors of hospital services in all the provinces of the country need to answer very explicitly to the Truth Commission to what extent they applied their own discretion in implementing apartheid policies in health care.

We also want to make the point that the private sector, which has enjoyed relative freedom from the constraints of public bureaucracy was also complicity in applying apartheid. Even to this day, less than three years from the turn of the century, we are still aware of racist discrimination in private practices. We’ve heard it today. We see it documented in the papers.

I think perhaps for time we would like to go on to probably the most important issues in the health sector, and that’s the issue, the failures of the organisations representing the health professions to distance themselves from the policies of the apartheid government. The neglect of Black health professionals was a common theme to all the disciplines and is symptomatic of the profound inability of the professions under apartheid to come to terms with their role as advocates for human rights. And as we have heard today these organisations covered up abuse, they acted as apologists for government policies, they actively vilified colleagues who were prepared to stand up for justice and human rights.

For example the language and concerns of the Medical Association, as they acknowledge, re-

flected a world view that believed in maintaining the security of the State above human rights considerations. But we also want to say that it was not only that, there were also issues of placing international esteem and status above the recognition that much was not well with the health of South Africans.

Notwithstanding the failure of MASA to take action against the doctors who treated Steve Biko; the MASA's failure to condemn apartheid and detention without trial; the abuse of the South African Medical Journal for its own political agenda, perhaps the most fundamental criticism of MASA is that it definitely was an organisation that was permeated with an anti-human rights culture.

In the 1980's, as Barry earlier pointed out, it sought and received advice from military officers. In our submission we also point to the fact that the 1977 MASA annual congress which was held in Bloemfontein in that year, ironically a city from which Indians would be forbidden to be present in for more than 24 hours without a permit, had a session focusing exclusively on military medicine, and this was hailed as a great innovation. We want to ask why in the year following the Soweto uprisings, with the bloodbath that swept the country, there was not a mention of the costs to human health and human rights of this uprising, and yet the Medical Association chose to make military medicine a feature of its congress in that year.

We think it's not only in the formal links with SAMS that an association with security concerns can be built, but it was very much within the culture of the organisation.

To this point we also want to refer MASA to the book, the Super Afrikaners, in which it is fairly easy to identify members who were Broederbonders. In fact the general secretary of the - the former general secretary at the time was a Broederbonder and as far as we could tell at least three of the publications committee members in the eighties were members of this organisation. We have no idea to what extent the Broederbond membership permeated other leadership structures of the organisation.

Now we do acknowledge that the MASA of the nineties has clearly undergone major changes, but it's not apparent whether these changes involve a change in the fundamental culture of the organisation. It appears, and certainly from the submission made today, that an assumption that increasing Black membership of the MASA is going to solve the problem, but it's not clear to us whether MASA is really able to appreciate and operationalise a commitment to human rights.

For example the comment made earlier that MASA's commitment to self-examination was only

possible because of the TRC process is profoundly disturbing to us. We cannot see why a professional organisation that would seek to maintain the standards of the profession could not have embarked on this process long ago through mechanisms and structures that it could have developed entirely independent of the TRC.

Secondly, we are not quite clear why the organisation has to wait for a complaint about members who practice apartheid medicine. One simply has to go, drive to De Doorns in the Boland and see the farm workers standing outside the garage in the rain while the paying patients, most of whom are White, but some of whom are Black, are inside in a comfortable waiting room.

And many of the MASA leadership live in Cape Town and would have had the benefit of a Cape Times supplement examining the state of the Nation in which an advice office worker in Coligny in the Free State says very explicitly the local general practice is racially segregated. There is no reason why one has to wait for a complaint to reach the organisation before one acts on that.

I do believe that the MASA is genuinely committed to addressing these issues but it needs to demonstrate that in practice. I think many of these issues apply to other professional organisations as well.

Further, we need to examine the role of the Councils, and that's been touched onto some extent. I think yesterday's presentation by the Council confirmed our greatest concern that we don't understand why the Council cannot be pro-active about defending human rights in this country. We want to know what part of legislation actually precludes the Council from establishing a commission or from doing an investigation, or from commissioning a university or an NGO from doing some work to defend human rights, or to establish human rights in the health professions. I don't think that has been adequately answered and it points to a critical issue in the need for fundamental reform to the Councils.

We do want to make the point that not all health professionals chose to comply with abusive practices. There were many health professionals who actively defended human rights under apartheid repression and many who paid dearly for their actions. The point we wish to make is that notwithstanding the context, the overwhelming plethora of security legislation and power, individual doctors and other health professionals could and did make choices. And when we consider the history of the health sector we need to be clear that there were choices that could be made.

In terms of common themes the one issue that emerges all the time is clinical independence of health professionals being compromised, either by a plethora of legal and institutional frameworks or by the active complicity of health professionals. There obviously were cases where health professionals may have unwittingly participated in human rights violations, but there were also cases where health professionals have been more than active in taking steps which have led to the violations of individual human rights.

We also want to make the point that even though there was a plethora of health legislation, a plethora of security legislation, there were a whole stratum of regulations and administrative practices in hospitals in the district surgeonancy that emerged out of dark offices that were simply borne out of the culture of the health services service to the apartheid security forces. So hospitals would gag their own staff, district surgeons would be subject to certain internal directives which prevented them from taking steps to protect their patient's health. These institutions reproduced the apartheid states' intentions at local level to ensure that health professionals were compliant.

However, when we highlight the power of the contextual constraints we do not argue that individual health professionals can be absolved of responsibilities. To do so would be to introduce the degree of de-construction that is not grounded. Quite simply one cannot say, for example, that district surgeons can be absolved of any responsibility for complicity in detention or the death penalty, or corporal punishment; military doctors who received orders to assist in torture by applying medical skills were not devoid of choices. Psychologists who were drawn into devising better ways of interrogation cannot simply rationalise their contributions as technical. The toxicologists whose skills were put to use in covert operations cannot argue as the Nazi doctors did that they were simply doing their job.

I think Wendy, as a Commissioner, in her case, it's a clear example where action could have been taken, but we need to ask why there were not more district surgeons like Wendy who refused to comply with these practices.

The evidence presented in our submission supports the notion that many health professionals acted more freely in abuses. They never attempted to offer assistance to tortured and injured, they effectively really covered up the footprints of the torturers.

And one way of looking at this is in terms of parallels with other countries. In his reinterpretation

of the Nazi holocaust Daniel Golhargen(?) suggests in his book that the traditional theories for explaining the complicity of ordinary Germans in the Jewish genocide cannot be entirely plausible any longer. He argues it is difficult to attribute participation in mass killings to the fact that Germans lacked a voice or options or that they were responding to social psychology of group dynamics that compelled them to commit atrocities against their will. To the contrary he argues that the Germans participated willingly in the abuse, torture and killing of Jews because of the annihilationalist anti-Semitism that permeated German society.

We believe that similar arguments could be made for the complicity of health professionals in human rights violations in South Africa. The implication of this is that we must reject the bad apple notion of complicity. It is insufficient and indeed misleading to argue that it was only a few deviant professionals who led the whole profession into disrepute, and rather than identifying a convenient number of scapegoats we need to look at the profession as a whole and understand what made the profession so inherently amenable to cooption by an ideology that denied human rights.

It's particularly in the area of the lack of professional accountability that this emerges. The statutory institutions, professional organisations abdicated their responsibilities and in particular they failed the profession and the South African people by refusing to hold individuals accountable for human rights abuses. We have little doubt that if the organised health professions had sent a stronger message to doctors, namely that unethical conduct would not be tolerated and would result in severe disciplinary action, the history of complicity by health professionals in human rights violations would have been very different.

In closing this off we also want to remind the Commission about the private sector. Our contention is that health care providers and corporate interests in the private sector have roles and responsibilities that require examination and redress. We believe this is a big gap in the current approaches to achieving reconciliation through the TRC and we would like to believe that the TRC shares our concerns related to the need for redress of violations of socio-economic rights.

As part of the reconciliation process and of reestablishing trust in the profession we argue that, for instance the environmental and occupational health impacts of activities in the private sector, should be subjected to the same process of scrutiny as initiated by the TRC. In the long term reconciliation can only

be achieved by disclosure of what went on in the private sector as well and a genuine commitment to facilitating redress.

In conclusion, the challenge is for the health sector, and that is the whole health sector, the institutions, those of training, of research, of professional regulation, for the organisations of the profession and for the State health services and the private sector to embark on some process of serious self-examination. What could have been done differently? Why could it have not been achieved? Did we know enough as to why it wasn't achieved? Where were the role models? Has enough been made public to understand what went wrong?

There are many other questions that arise in this process, to answer them effectively, honestly and openly is the challenge facing us. Abuses continue to occur in the health sector. The process is then not only about digging up the past but about creating an ethical framework to guide health professions in the future.

We have made extensive recommendations, I am just going to mention some of them, perhaps the most important ones. We believe a legally binding code of conduct for all health professionals that specifically prohibits participation in human rights violations should be adopted. There should be a special commission on health and human rights established to implement the recommendations that arise from these hearings and others. The commission should be comprised of, but not limited to, members of health professions, should include human rights experts, legal advisors and community input. The commission should have the confidence and support of key stakeholders in the health professions.

There is a great deal of archival material which we believe is still available if it hasn't been shredded. The TRC should use its legal powers to obtain this material in relation to human rights violations in health, in particular copies of district surgeon reports, reports from the International Committee of the Red Cross, Health Department memoranda and security force records.

There should also be ongoing documentation of past and current health and human rights abuses. Cases of abuse should be fully investigated, and we are particularly calling for the reopening of past cases where evidence of complicity exists.

We also put a challenge to the institutions responsible for training of health professionals to look seriously at the question of human rights education and to make it a fundamental component of curricula.

That institutions are to be transformed to create a culture that respects and promotes human rights and produces graduates who are capable of seeing advocacy for human rights, advocacy for their patients as being part of their responsibilities.

We believe this hearing will begin a process that will help all of us reach a common understanding to establish a culture of accountability, of respect for human rights and a re-adoption of the notion of health professionals being advocates for the vulnerable. This we believe is part of the healing calling of the health professions and should be reasserted as an indisputable and inseparable element of the profession's ethos. Thank you.

MS GOBODO-MADIKIZELA: Thank you Leslie. The Health and Human Rights documents it's really quite extensive and it's a pity that we haven't been able to deal with many of the specific issues that you have researched in the documents. But I want to engage you just for a moment on one of the arguments that you make because I think it is important if you are going to be thinking about reconciliation and the redress of some of the pertinent issues in the abuse of human rights in the practice of medicine and in other sectors in general. You say that you give the example of people like Wendy and other individuals who stood up for the rights of their patients and you made the point that if people like Wendy could do it, why couldn't the number of people in the health sector who could also speak out, why couldn't they do it. What worries me, I think it is a concern, but this is true in many sectors of our society in the past, of our history, these questions could be raised in relation to education, to military service where some people left the country or some objected and so forth, but the majority, always it is the majority who do not speak out. And I wonder what your views are about why it is that only a few people always speak out and the majority of people don't speak out against the abuse of human rights.

DR L LONDON: In a sense the issues have been touched on by various people. I think at an individual level there are questions of fear, of political alignment world view, but I think in the context the professions failed to support or failed to provide role models for people to say we will support you if you speak out, or we think this is the norm, the problem was that the training institutions, the professional organisations were reproducing a norm which was entirely devoid of any social conscience. We believe that had that been done differently it would have been less easy for doctors and other health professionals just to ride on what was happening.

MS GOBODO-MADIKIZELA: Yes, Madam Chair, sorry, I think that you are right, but the concern is that these kinds of modalities have been reproduced throughout the world. There have been, I mean you referred yourself to the holocaust and to the book, The Willing executioners of Germany, the reality is that people live in an environment that propagates a particular kind of culture which starts from the education of the young, the teaching of certain modes of behaviour, the exclusion of certain individuals, the abuse of certain groups in the population and people learn about this from a very early age. And I think we should be looking at a different way as a form of social engineering which could address these problems rather than look - yes we could look at individuals as well, but I think largely we should perhaps be looking at different forms of social engineering that could re-teach or teach new moral behaviour in this country, and that is my view even as far as it relates to medical ethics. We need a re-teaching of moral behaviour of new ethics in a different way that will start people at a very early age of their education and I think that way we might be able to have some kind of achievement in the area of the learning of human rights. That is my last comment and I will welcome a comment from you and we will end up the conversation.

MS MKHIZE: Maybe if I might just come to your protection I should think the comment that you have just raised let's take it as food for thought. Thank you very much for giving us what is like a synthesis of the debates that have gone over these two days, and also for setting a tone and a challenge for people who will be picking up these issues. Thank you very much. Other people will have an opportunity of debating these issues later on during the plenary meeting.

DEPARTMENT OF HEALTH SUBMISSION

MS MKHIZE: At this point in time I would like to invite representatives of the Department of Health to take a seat please. While they are coming forward I would like to read two messages of support.

The first one is from the African Christian Democratic Party. I am reading this without implying that you are under the string of Cabinet. It says,

“Our party believes that it is vital for the TRC to examine the role of health professionals in human rights abuses in South Africa and to document as fully as possible all gross human rights (...indistinct), professional violations perpetrated by the health care sector during the period from 1 March 1960 to the cut off date which is 1994”.

Also from the Mpumalanga Provincial Government, Department of Health, Welfare and Gender Affairs, it says,

“The above Department appreciates and supports the process the Truth and Reconciliation Commission has set forth. Although we will not be attending the meeting on the 17th of June 1997 this will ensure, to a great extent, that human rights abuses in the health sector do not recur in the future”.

Gentlemen I will ask you to mention your names and to take an oath please.

OLIVER PRETORIUS: I am Oliver Pretorius, Deputy Director of Department of Health.

MELVYN FREEMAN: I am Melvyn Freeman, Director Mental Health and Substance Abuse.

TIM WILSON: I am Tim Wilson, one of the Chief Directors in the Department.

DR OLIVER PRETORIUS: (sworn states)

MELVYN FREEMAN: (sworn states)

TIM WILSON: (sworn states)

MS MKHIZE: Thank you. Dr Ramashala will then assist you in talking to your submission.

DR RAMASHALA: Good afternoon gentlemen. You know Dr Pretorius it would not be true to my nature if I didn't comment about the gender representation - (General laughter), yes, and colour. Before I proceed may I say thanks for your patience. I know you have been sitting here for two days and there is a method to this madness, it was by design to actually assign you to the last submission. It was very important for us that you listened to the two days testimony because ultimately it is the Department of Health that is held accountable as the national health accounting structure, and I hope that you were able to benefit from the presentations for these two days, and that the presentations will help you in terms of joining us to move forward to address the very serious problems that are facing the South African health care system.

May I make a comment and say that, is it correct that this is just a preliminary submission, am I correct? Okay. And you don't intend to read it in its entirety are you? Okay. May I ask you to proceed and then I'll come back to prevailing questions.

DR PRETORIUS: Madam Chairperson, Commissioners, Ladies and Gentlemen. True to my personality I would not comment on the fact that we are addressing a Commission only consisting of women. (General laughter)

It is for the Department of Health and for me, as a public servant who served in those dispensations, an historic and important opportunity to make this submission today. This presentation is a short overview of the full submission already submitted to the TRC. And in the light of what has been said today I am pretty sure that we will have to make a subsequent submission dealing with the issues that have not been dealt with sufficiently in the initial one so that we can provide a comprehensive response.

Before I start I would like to clarify my terminology that I will be using. When I use the term

“Department of Health”, unless I specify otherwise, I refer to all health departments during the previous 30 to 40 years at the national and provincial level. This will also include the health departments of the then independent and self-governing states and thus also by implication the various departments responsible for the budgeting and governance of the various homeland structures, such as the Department of Foreign Affairs and the Department of Development, Cooperation or whatever name was used during the various phases of its history. And the departments of health of the Tricameral system. I am, however, not speaking on behalf of the political functionaries who were the final decision and policy-makers.

The Department of Health was not a passive functionary only carrying out political orders. It was responsible for drafting and the practical implementation of the policies of the State, and that fragmented system of the past with provinces being quite autonomous and the various homeland governments being also autonomous this created the formula which allowed different interpretations of present policy in various areas.

This period was marked by legislated racial discrimination, segregation and oppression, which not only affected the organisation of health services, but also the health of the people.

Although the full consequences of the policy of apartheid were never anticipated nor acknowledged during the time when it was developed it is well researched and well documented. In this submission I will briefly outline how the department acted as part of the apartheid apparatus leading to ill-health of millions and the unnecessary death of many South Africans.

It is the responsibility of every person working in the health department today to ensure that never again will we allow practices and policies to be developed and implemented that will ignore or abuse the health and human rights of our people as it was in the case in the period under review.

The health status of the population is a measure of more than just health services, poverty, employment, access to water, sanitation facilities and other socio-economic conditions are major determinants of health status in the country. However, it is worth looking at the health status during the period under review as it reflects important patterns of health and health care which can be considered as violations of human rights. Quite a number of speakers during the past two days have referred to various aspects of it.

Through the period 1960 to 1994 the health situation in South Africa reveals two distinct patterns

of disease and health status for Blacks and for Whites respectively. Differences between the mainly Black rural areas and the urban areas are also stark. White South Africans have had the infant mortality and life expectancy rate similar to countries in the developed world. The figures for Blacks were similar to the underdeveloped world. For the period 1965 to 1970 the life expectancy for African males was 51 and for females 60 years. For Whites during that period the figures were 65 and 72 years respectively. During 1985 the figures for African males was 55 and 61 compared to the 68 and 76 years respectively for Whites. The life expectancy of the Indian and Coloured people fell between the White and the African figures.

The following figures of estimates of infant mortality rate by population group and in rural areas in South Africa speaks for itself. The IMF for South Africa during 1981 to 1985, excluding the TBVC countries was 94 to 124 for Africans, 51,9 for Coloureds, 17,9 for Indians and 12,3 for Whites. In the urban areas the situation was that the IMF for Africans was 38,6; for Coloureds 25,9; for Indians 17,1 and Whites 12,3. While in the rural areas the figures for the African population was 100 to 135; for Coloureds 66; Indians 19,8 and for Whites 12,3.

High incidence of kwashiorkor and marasmus have been extensively documented and clearly link the policies of the day to such - such as the Homeland system and the migrant labour system. It was estimated in 1989 that there were 2,3 million people in South Africa, including the TBVC countries, who could be considered to be in need of nutritional assistance. Of these 87% were African and 2% were White. Active nutrition support programmes, however, only started in the latter part of 1992.

The disease patterns reflected major differences between the White and Black South Africans during that period. Amongst Africans and Coloureds diseases such as tuberculosis, pneumonia, enteritis ... (intervention)

MS MKHIZE: Dr Pretorius can I just ask you to put a mike close to your mouth, some people can't hear. Thank you.

DR PRETORIUS: Amongst Africans and Coloureds diseases such as tuberculosis, pneumonia, enteritis and other diarrhoeal diseases were the major causes of death. In 1978 typhoid fever was 48 times more common amongst Blacks than Whites. In 1971 deaths from diarrhoea were 100 times more common among Black children than White children in the Cape Town area.

In 1987 African women had 3,5 times higher rates of cervical cancer than Whites. The health system was, however, geared for disease patterns of the Whites who, for example, had higher levels of ischemic heart disease and diseases common in the western world. On neither quality nor quantity of service can be completely correlated with the financial input. It is certainly clear that without financial resources to provide adequate services health care will suffer.

The allocation of inequitable resources is probably the single most important factor for which the department can be held responsible, for that resulted in the inequities between the different areas in the country. The per capital expenditure on health care ranged from, during 1985, for Africans, R115,00; for Coloureds R245,00; Indians R249,00 and for Whites R451,00. During 1987 the figures were as follows. For Africans R137,00; for Coloureds R340,00; for Indians R356,00 and for Whites R597,00.

According to the Brown Commission in 1984/85 only 12% of the public health expenditure went to the Homelands where perhaps 40% of the population lived.

I would like to refer now to the issues related to the health care of detainees. Much has been said yesterday and today about the problems experienced by detainees, and rather than to repeat what was said I will confess that the way in which some of the staff of the Department of Health treated detainees and disposed of their roles as the watchdog of the health of the detainees was questionable to say the least. And that as a result of that the health and human rights of many people were violated.

It was the duty of the district surgeon to record physical and mental signs of torture and abuse and to report these for the necessary action. It appears from the evidence presented at this meeting that medical negligence was a factor in the deaths of a number of people in detention. Many district surgeons were put in the invidious position of having to comply with the Prison Act and the Emergency Regulations and cooperate with the law enforcement authorities on the one hand, and the principles of their own medical ethics on the other hand. Most district surgeons appear to have opted for the former, either out of commitment to a political ideal or out of fear for not doing this.

We have no evidence that doctors actively participated in torture, except one case that was mentioned yesterday, but nor did they expose torture when it was evident that it had occurred. As the employer of district surgeons it is incumbent on the Department of Health to bear some responsibility for the fact that it created the mindset for the district surgeons to become accomplices to actions resulting in unneces-

sary illness and death. However, it is important too, for the Department of Health to accept blame for not having taken sufficient action to enable district surgeons who wished to report on malpractices that became evident through their medical examination to do so without fear of victimisation.

In the one case where a district surgeon did attempt to protect the rights of patients who were being tortured authorities in the Department of Health did not give their support and in fact even obstructed her.

Often youngsters and children were injured in clashes with the police. When they went to the health services for care many were duly arrested either before or after initial treatment. As result of this many people refused to go to the health services for treatment. This resulted in the creation of community initiatives to care for the injured in clandestinely set up surgeries. By not acting against such practices the Department of Health was in fact collaborating with the police services against the health interests of their patients.

The Department of Health had little to protect the professional confidentiality and in fact collaborated with the police in producing information. There are numerous reported incidents in which doctors, nurses and administrative staff were forced to give information, often with threats against the health worker or their family.

Like in other forms of medical care psychiatrists and psychologists were faced with the dilemma of fixing a person up to be returned for further abuse. In such situations the practitioner cannot withhold treatment in order to avoid being an accomplice to further interrogation or torture. With patients needing psychiatric care the chance of a fairly rapid decline was probably higher than with most other illnesses. The onus was on the practitioner to recommend that the person be discharged, or at least put into a slightly more normal situation than, for example, solitary confinement or isolation.

When a number of patients were referred to a hospital to be treated for various conditions, some of which may have related directly to the detention and some of which were unrelated illnesses they were handcuffed to the bed to ensure that they did not escape. This included patients sent for psychiatric care as well. The now Premier of the North West, Pope Molefi is reported to have been kept in leg irons while being treated for a lung infection.

The Security Police took action against many people who opposed the apartheid system and a list of health personnel who were detained and harassed during that time is available.

The proposed new policy on medico-legal services in South Africa has been accepted by the PHRC and will now be submitted to the MINMEC meeting for consideration, and I think that this is a major breakthrough to move away from the kind of problems that have been discussed over the two days.

Much of the family planning services of the department were directed at controlling the size of the Black population. In 1981 the director general of this department warned that sterilisation and abortion might have to be made compulsory unless certain ethnic groups accepted family planning measures. Fortunately this was not enforced. This reflected the underlying motivation of government for the Department to allocate higher priority to family planning than to its primary health care services.

The allegations of human rights abuses in South African psychiatric institutions came to a head around the mid-1970's following a number of newspaper articles which documented violations in the mainly State subsidised institution, the Smith-Mitchell Company. There was also major concern internationally that South Africa, like the USSR was committing political dissenters to psychiatric institutions.

During 1978 the American Psychiatric Association visited South Africa to investigate all the Smith-Mitchell Hospitals. They were, however, not given the same access to State institutions.

The following findings were recorded:

An unduly high death rate;

Substandard care;

Some instances of abuse practices;

Grossly inadequate professional staff;

Possible exploitation of patient labour; and

Apartheid had destructive implications on the mental health of Black South Africans.

The APA also found that treatment of Black patients were substantially worse than those of White patients. They also made findings, such as, that patients were provided neither with toilet paper nor washbasins adjacent to toilet facilities. Black patients, by policy, are not provided with sheets, and that the majority of Black patients answered in the affirmative to the question of whether they had been beaten or assaulted by staff.

The then Department of Health found the APA report to be completely unacceptable and is rejected as prejudiced, biased and a masterpiece of malicious misinterpretation of facts. We have no reason

to believe that the APA had reason to misinterpret the facts. This together with similar allegations contained in a 1996 investigation into psychiatric institutions led us to assert that most of the contents of this investigation were in fact true. The APA deserves an apology from the Department for, in essence, calling them liars.

As with all health services emergency services, including ambulance services were separated by race. Inevitably patients died because they were not given timeous treatment which they could have received had they not been of a different race group. Because admission to hospitals was racially based patients were forced to go to hospitals which were not necessarily the nearest or the most accessible. In terms of ambulances they were despatched to emergency situations based on race. As a result if an ambulance serving the Black population group was in use a patient would have to wait rather than an ambulance reserved for Whites being despatched.

The task team responsible for the development of a new emergency health care service policy has advanced fairly well and will be on - the coming Friday, will discuss the final policy document which will then, if accepted then, be submitted to the PHRC and the MINMEC for consideration.

Personnel abuses: Many hundreds of South Africans can justifiably blame the Department of Health for the fact that they were not given the opportunity to advance into a medical or related career. While much of the blame for this must be borne by the Department of Education, for example, the Bantu Education and University Extension Act which essentially barred most Blacks from being educated as medical and related practitioners the Health Department must also carry some responsibility.

Under the Extension of University Education Act of 1995(?) non-White students were accepted into universities only with Ministerial permission. During 1978 83% of Indian and 95% of Coloured applicants were granted permission while only 29% of African applicants were accepted, or were given permission. Between 1986 and 1977 88% of all new doctors who were White and 3% were African. The indignity of having to ask permission from a Minister to study was heartfelt by students.

The issue of discriminatory rules with regard to the training of Black students in White institutions were mentioned by a number of speakers and therefore I will not refer to it in any further detail.

Other professional groups were similarly prejudiced in terms of admission and training. The opening of the Medical University of South Africa was part of the grand apartheid plan which was aimed

at having fewer Black doctors trained at White universities.

Despite equitable qualifications between White and Black personnel for most of the period under review discriminatory salaries were paid to Blacks. This includes nurses and other professionals. In addition facilities and conditions were separate and unequal. Personnel working in the same facility and with the same qualification had separate toilets, separate tea rooms and separate accommodation.

Despite Black health personnel sometimes having better qualifications and experience White personnel were promoted above them. It was seen as unacceptable to have Blacks in position of authority over Whites. Within the Department of Health no Black person had been appointed at director level or above until the new democratic dispensation.

With minor exceptions women were also not appointed to senior management level. The new human resource policy that deals effectively with these concerns is in its final stages of development.

In accurate representations by the Department of Health: We believe now that the Department of Health and other government departments were responsible for giving inaccurate and distorted perceptions of health and health care in South Africa. These were often done deliberately to promote South Africa's standing in the world and for other propagandistic reasons.

Conclusions: Apartheid could not have existed without the apparatus which constituted it. The Department of Health was one such apparatus. In this historical overview of the health services over the past years it became quite clear that the Department of Health played a significant role in creating and maintaining apartheid. In terms of human suffering this Department has much to answer for and much to apologise for.

Rather than allowing health to be the driving force of its policy this Department concentrated most of its efforts and resources on only part of the population in line with the political objectives of the apartheid state.

The Department also became part of the oppressive apparatus of State by not taking stands and intervening when medical ethics were being violated even by their own employees.

At a number of points in this submission we have suggested how the Department may have acted differently. We make apologies to those discriminated against in terms of the poor or no health services resulting from the inequitable and racist allocation of resources.

We make apologies to those detainees and their families who did not receive adequate health care, or who were abused by employees of this Department by commission or omission.

We apologise as the Department of Health for not taking the actions necessary to ensure that such abuses did not occur and for not supporting those who did object to torture and other abuses of medical ethics.

We apologise to those activists who were not protected by the Health Department and may have died or have permanent injury as a result.

We apologise to the patients who have been violated at psychiatric institutions.

People who have suffered as a result of emergency services' practice along racial grounds.

We apologise to people who would have wished to become part of the health personnel but were not allowed due to race.

To practitioners who were discriminated against in terms of training, salaries, facilities and for acting against apartheid. Those who suffered as a result of this Department's policies.

But before I conclude, I would also like to use this opportunity to thank the large numbers of dedicated health workers who have, on many occasions, worked long hours under sub-optimal conditions to fulfil the professional mission of a caring health service.

As the Department of Health we will be doing all within our knowledge and power to ensure that the wrongs of the past are not repeated. However, we would welcome any input from the Truth and Reconciliation Commission to assist and guide us in creating a quality health care system.

I thank you.

DR RAMASHALA: Thank you Dr Pretorius. I am going to approach this in somewhat the same way that I approached the SAMS. The numerous questions that I have, and if I have to go through the questions we'll be here until tomorrow. What I would like to recommend is that I go through the questions for the public record, where you want to comment very, very briefly, like one second, you may, but what I would like to do is to have you respond to these in writing, in fact some of these questions will require that you do some research.

Thanks to the AAAS in reinforcing the way I've categorised the questions we somewhat agree about the broader range of issues, I've approached it from the perspective that as a national health service

your primary responsibility is policy and accountability. So there are four broad categories that I want to outline and then I'll go into the questions.

The first one, which is exactly the same as the AAAS recommendation, is the issue of regulation and enforcement. And under regulation fall the issue of financing of services, organisation of services and even management of services.

The second one is accountability which is a part of enforcement. Under that comes monitoring. How do you know in fact that the health services that are provided are of quality, they are accessible, all of those things? And corrective measures under accountability, and that relates to the issue of the code of conduct of health professionals.

The third one is capacity development which you allude to in your document very briefly. I would like to know if the Department in fact has a grand plan, and we are talking here not only about the issue of redress but accessibility of services with the difficult populations like the elderly and in rural areas. What is the Department's grand plan in capacity development.

And the last one is the issue of education, and I've divided it into two. The first one is education including skills development, that is the training of medical professionals. The second one is re-education and rehabilitation, and that speaks to the issue of abuses beginning with district surgeons all the way through the system.

Let me go through the questions and I think you have a preliminary copy of that. I may have variations.

The first one is,

1. Could you briefly discuss whether there were specific national health policies which were formulated at the time which would account for the following in terms of differences, and I've only chosen four areas. You've identified a whole lot in your document, but I just want to deal with four for the purpose of the record and then you can deal with the rest.

The differences in life expectancy rates in South Africa. Which means you are going to have to take all the populations.

The second, infant mortality rates, particularly between Africans, Coloureds and Whites.

The third one, urban - rural differences taking into consideration the fact that the poorest

services are in rural areas and that's where the majority of older people, very poor people and children are.

And finally under that question, diseases of the poor. And in this case I've used malnutrition. Not much has changed, the poor are still poor. The poor still don't have running water. The poor still don't have electricity. The poor still don't have good sanitation.

And so we've got to address the diseases of the poor and I'm looking at the issue of health in the broader perspective not just as the absence of disease.

The second question is inspired by a section in your document and I'll quote:

“In 1978 typhoid fever was 48 times more common among Blacks than Whites. In 1971 deaths from diarrhoea were 100 times more common among Black children than White children particularly in the Cape Town area”.

Could you examine policies which formed the bases for the allocation of health resources at the time, with specific focus on prevention strategies versus curative strategies for both Blacks and Whites.

I mean we didn't just thumb-suck per capita expenditure something guided us in terms of the allocation of funding for services, and it is that something that I'd like you to go back to your legislative morgue so-to-speak and dig out those policies that guided these decisions.

The second question under that;

What was the thinking on the part of the Department at the time toward health care policies specific to prevention services and who were the main beneficiaries?

Again this was not just a thumb-suck, there was some thinking, somewhere in the Department and it's very important for us to know what that thinking is.

I think it is wonderful to apologise but I think until we know the basis for these decisions it will be difficult for us to move forward.

The third question, I refer to page 4 of your submission under “Resource distribution”, you note that, and I quote,

“The allocation of inequitable resources is probably the single most important factor for which the Department can be held responsible for past illness and death”.

Again do you have a record of policies and procedures which provided the basis for the allocation of resources in the Department of Health? And I'd like you to enlighten us on that.

Fourth question, refer to page 6 of your document and I quote and I won't quote the whole sentence,

“The exact effects of segregation ‘cannot be allowed to be repeated’. The separation of health care facilities, particularly hospitals, was a nationwide practice with deleterious health effects especially on Blacks”.

Would you please refer to policies which were the basis for such separation and how the Department proposes to address the still continuing inequities?

Again this was not a thumb-suck in South Africa to separate facilities, something guided us, and I think it's important to go back to that something which guided us.

5. Would you please give an overview of the 1984/85 Brown Commission Report focusing especially on its recommendations and the Department's follow-up of these recommendations.
6. Do you have a record of areas, and I'm talking about geographic areas, where district surgeons failed to perform their duties as outlined on page 7 of your submission?
7. Would you give us your thinking about underlying factors which contributed to the neglect of duty by district surgeons.

Let me give you feedback, that it is of concern nationally that these very perpetrators or people who neglected duty, and I think we've Sectioned 30 Dr Lang for example, he is sighted all over, that he in fact has been returned to duty by the Department. And a question that I have about this is how can we guarantee non-repetition of these practices, has Dr Lang and others gone through a rehabilitation process to ensure that such neglect does not continue?

8. Again I refer to pages 8,9, what follow-up strategies have been undertaken to address the cases that you identify on pages 8 and 9 of your submission, particularly with respect to corrective measures?

I think by apologising as a Department you are letting off the hook the real perpetrators, the Dr Lang's, it is very important that we get an accounting of this and how the Department plans to deal with it. Dr Lang should not be allowed to continue to practice unless he's gone through a rehabilitation process.

9. Would you give an overview of the 1978/1982 regulations as highlighted on page 10, I think they are important. What is the current status of these regulations? And comment on whether these regulations are sufficient to address recurring problems.

10. Refer to page 11, the last paragraph, what provisions has the Department made to follow up on the many people who were tortured and injured in other ways throughout the struggle, particularly those who were physically and emotionally disabled as a result?

Has the Department investigated the effects of the violations, particularly the long-term effects?

Are these patients receiving treatment? Actually let me call them persons because I don't know if they are receiving any treatment.

If the Department has not done any follow-up how then can we be certain that their health problems will be addressed?

I am acknowledging that the Department has more pressing priorities, but I would like the Department to deal with that.

11. Clearly access, both financial and geographic is an important aspect of health care, would you please address the issues raised on, and I quote, "Independent panel of doctors" on page 12, and the comments you make on the last paragraph.

And as I am talking about the issue of access earlier in your document you sight the figures for the four population groups in terms of per capita expenditure for health and you sight the African figure as 137, I would like to correct that and suggest that I don't think you factored in the fact that the hospitals were located at a distance and for Africans they had to have transportation to get there and so the figure is much lower. And so when you recalculate please take that into consideration.

12. Page 15, and I quote,

"The Department did not provide guidelines for such situations....."

which you identify on page 15, could you comment further on this especially on whether the Department has since addressed this issue which is crucial?

13. We know that certain family planning practices, for example, the case of depo provera were forced on Black women. These practices we know have long term effects. Have studies been done in South Africa, particularly by the Department to follow-up on these women, especially with respect to long term infertility and cancer?
14. Comment specifically on the abuse of patients, including what seemed like condonation of this behaviour by other ministries. You allude to it, wetting our appetite, but you don't go into it. You see we want to see how other ministries colluded with the Department in these practices.
15. Review of human rights violations in psychiatric institutions, what is the current status of the conditions in psychiatric institutions? I know that you referred to a study.
16. What is the status of the plan tabled by the current Department for ensuring non-repetition of abuses in psychiatric institutions?
17. Under emergency services we used to joke about it and say if you are Black don't you dare have an accident in a White area, now of course Whites were safe they couldn't have accidents in Black areas, but in order to survive we joked about it, we would like to know the way forward specific to what you address on inequitable access to emergency services.
18. And then you talk about capacity development briefly. It is important to address the issue of capacity development in the medical and health professionals broadly, including physicians, nurses, allied health professions etc.

Does the Department have a grand plan, especially to assess issues related to access to Black areas and to rural areas, the more difficult areas of health need?

19. And on the issue of misinformation you very honestly outline the areas of misinformation, particularly to the international community about the health status in South Africa. What are the proposed strategies, first, to correct his misinformation? And further to deal with the issues of inequity that are still persisting and how the nation gets to know about them?

20. There is a question that I have received from one of my panel and it says, Our research indicates that until the 1940's South African mental hospitals were under the Departmental of Prisons, do you think locating mental health within the Department of Health has made a difference in terms of patient care? If so in what way?

21. My last question, that is the way forward from the broader perspective, but specific to three issues:

The first issue is the treatment of people in correctional institutions and the treatment of detainees.

And the Department's role in involvement with the TRC, but with other more permanent structures, that will go on after the TRC, in formulating issues related to rehabilitation policy.

I sent you our document, I hope you received it, which really clearly categorises our findings of what was presented to us in terms of medical problems, emotional problems and other problems that are related. We would like to involve the Department in re-working that framework so that when the TRC leaves at least the Department can be left to address those issues.

Finally, what is the Department's strategy to ensure a culture of human rights within the broader health sector community?

I think what is even more important is that the Department has to institute corrective measures, because it is devastating for people in the community when they see the same district surgeons who perpetrated abuses continuing in the same positions. What is the Department doing about that? We are not suggesting that we get rid of those people, I mean that would have been my preference but I am only an individual, what I am suggesting are corrective measures which would include education and rehabilitation.

Thank you. Do you have any comments or lack of clarity on this?

DR PRETORIUS: Yes Madam Chair I would gladly deal with the questions asked by the Commission and supply the information as is available, although one realises it might be difficult to get it out of the fragmented system and a lot of that has disappeared, but nevertheless we will try and provide what is

available and put it into the necessary context.

I think it's also in the report that I have given was during the period prior to our elections, but if we do not get an opportunity to unpack what has been done subsequently in terms of the restructuring of the entire system, the development of new policies and pieces of legislation, that comes out of the considerations and the experience from the people whom we have heard were part of those that were disadvantaged and affected by the system. So that we have a lot already that we can be proud of, but we are not complacent about that. But the picture is a bit distorted and even the composition of our panel that the structure of the Department, the changes that took place there is well known in terms of gender issues as well as the issue, racial representation.

And that presently we are operating in the Department getting the input and the benefit and contribution and the value added from all of the people present in the Department. And that I must say it is nice working in a Department where there is so much openness and honesty as well as criticism. A lot of what's been done comes out of the bottom drawers of people working in the system but it was put on the table and what was good was accepted and what was not good was taken away. So it's a process of contribution and if you've got something to add and you can justify and you've got the facts to prove it it's accepted. If it's not accepted it's thrown out. Melvyn!

DR M FREEMAN: I think my comments are very similar. A white paper has just come out from the Health Department in which the whole restructuring of the Department is contained. There are also a number of policies which have either been accepted or are in the process of being accepted through various structures for the transformation of the health sector and I think that they need to be read to see the kind of movement that is happening in the Health Department and yes, as Dr Pretorius said, we were reflecting on a specific period which we were asked to comment on.

The second thing that I wanted to say is that we can develop some of these guidelines and frameworks for what to do with district surgeons or whether we should go back to the past or just look to the future, but I think our intention has always been that we would like to do it together with the Truth Commission so that it shouldn't be us going back, doing it, coming to you and then comparing notes. I think that we would rather like to look at the issues together and see where we should be going, and I think that's why the next session is so important for us. I think this is a bit overwhelming for us to have all

these questions bombarded at us, and I think that I personally take some exception to being equated with the submission from the Medical Services last night because I think that we really have attempted to examine that past and to look at what has gone wrong and to apologise where we have seen that things have gone wrong. So that's just a personal view of the facts.

DR RAMASHALA: You need to listen very carefully, you were not equated to SAMS. I said I will approach my questions somewhat the same way that I approached it. I hope you understand that.

Let me say that the Truth Commission, particularly the Committee on Reparation and Rehabilitation is making a commitment to work with you, but remember that in December we are gone, and so we have a very, very short shelf life, and whatever needs to be done in consultation with the Truth Commission is short-lived, however, we hope that out of this conference will come out some kind of task force that will be a continuation of the issues that are raised through the Truth Commission process to work with the Department on a long term basis. Thank you.

MS MKHIZE: In thanking you I would just like to reiterate some of the issues that have been raised by Dr Ramashala. For us these questions are serious, especially when dealing with the public structures like ministries. Some of the questions, we live with this contradiction all the time. When we meet with representatives of ministries we get this message that we have done so well, we have these grand plans on our table, but at the same time, at this point in time we have got about 10,000 statements, people who have come forward who really we have nowhere to refer. A significant number of people have died who have come before the Commission who couldn't get help because they are living in areas where the quality of health care is still disgusting. When it comes to mental health care it's difficult to describe what we are faced with on a daily basis. We have met with MEC's, we run around looking at the percentage of the crippled nation that is living with us up to today. So much as we accept that ministries have come up with grand plans, but the reality that we are confronted with on a daily basis it talks to the opposite.

So in thanking you I will really appreciate and thank you for making a commitment, and we will appreciate to get the responses to the questions that have been raised and to continue a dialogue. Thank you very much.

DR PRETORIUS: Thank you to the Commission, thank you very much again from our side, for the opportunity and we are also serious about this. But it's important that one needs a proper plan before you

can start implementing it, so that we are in that phase where we are developing the plans to make sure that when we operationalise it, it will be proper and it will be in line with the thinking of the government of the day. Thank you.

MS MKHIZE: Thank you. At this point in time I would like to thank my colleagues. Glenda will read out a few messages first and then Dr Orr will thank all the relevant people who have facilitated this, but before I hand over the Chair I would like to personally thank Dr Orr for working tirelessly on this project and making the process to be where it is today. To you I would like to really say thank you very much on behalf of the Commission. Thank you.

And then after Glenda has read out the letters of support Dr Orr will then thank everybody. Thank you.

MISS WILDSCHUT: Thank you Hlengiwe. We have received, as Wendy said yesterday, many letters of support. I am not going to read verbatim what these letters of support are, except to tell you where they are from and then also just to tell you the gist of what is contained in these letters of support.

We have a letter of support from the Human Sciences Research Council. From the South African Institute for Medical Research. From the TRC and Gender Group that is coordinated by Beth Goldblatt. From the South African Pharmacy Council and from the University of Zululand. All of them say something similar to this.

“Be assured of our full commitment to helping and healing of all concerned in this process and the prevention of human rights abuses in the future”.

And also many people congratulate us on having a hearing which focuses on the health sector.

Thank you very much.

DR WENDY ORR: To add to Glenda’s list and it goes on and on, we have one, a letter of support from the Department of Community Dentistry at the University of the Western Cape; the Human Rights Center at the University of California at Berkeley; SINTROS which is a health and human rights organisation in Chile; the Medic Alert Foundation; the Inter-American Institute of Human Rights; the Dental Association of South Africa; the Gauteng Provincial Government Department of Health and a health and human rights organisation in India whose name I am afraid I can’t pronounce. But I think this all just demonstrates that the issue of health and human rights is not only a national one, it’s an international one and the process

which we are going through together is one of immense importance.

Before I move on to thank all the people who have made this hearing possible I want to underline the importance of the meeting which is going to follow which is going to be chaired by Dr London.

We have to acknowledge that there are certain things which the Truth Commission is authorised and mandated to do and other things which it cannot do, and I think the time has now come for us to say that the health profession must decide what needs to be done about the issue of health and human rights. The Truth and Reconciliation Commission is certainly prepared to assist and facilitate and give whatever input we can, but as Mapule said our shelf-life ends on the 15th of December 1997, health and human rights issues will remain a concern for decades to come.

So I do ask that as many of you as possible do stay for the plenary meeting which is going to follow immediately after I have done the wedding reception thing of saying thank you to everybody. I always feel that everyone switches off at this stage, but it's really very important because these people have all made a tremendous contribution towards these hearings.

At the workshop in November last year we elected a task team whose primary task was to ensure that these hearings occurred and they have worked tirelessly for the last however many months, seven months, meeting regularly, spurring people on to make submissions, making submissions themselves and I would just like to name them. The membership has been a bit of a moving goalpost but the hard core group, as it were, consists of David Green, Leslie London, Donald Skinner, Rachel Prinsloo, Gavin Dampster, Sheila Clow, we had a representative from the Progressive Primary Health Care Network who tended to change from meeting to meeting, and latterly three researchers joined us, Laurel Baldwin from the Health and Human Rights Project; Sheila Roquitte, who is a research intern here at the TRC and Lionel Nicholas, who was asked by PsySSA to help them with their submission and who actually presented their submission. This group, without a doubt, has made the last two days possible and I personally want to thank them for the practical and the emotional and spiritual support that they gave me as I worked towards these hearings.

I want to thank the TRC staff who have worked, Thulani and Wilhelm who have been here, but who aren't here now, for the past two days, who are going to help us in pulling the proceedings together and documenting them; our logistics officers Gayle and Elizabeth; Linda van Demen my secretary who

has dealt with mountains of correspondence and faxes and submissions and Martila Naidoo who is our support services manager in this office.

Thanks to the South African Police Services who provided security. I think they have been quite unobtrusive but I can assure you they were here every morning at 7:30 with their sniffer dogs making sure that these premises were safe.

The translators who have a very difficult job. I think simultaneous translation is one of the most difficult things to do and they always somehow need to manage.

And then to my fellow panellists who have also worked very hard in going through the submissions allocated to them and in compiling questions. Thank you very much.

Today is the end of one process and the beginning of another, and I look forward to seeing that process through with very many of the people who are in this room and many who aren't in this room as well. Thank you very much.

HEARING ADJOURNS