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TRUST: A CASE STUDY OF THE INTERSECTION OF DOCTORS' AND JOURNALISTS' ETHICS

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Johannesburg,

8 May 2014

DECLARATION

This research report represents my own original work, produced with supervisory assistance. All the relevant sources of knowledge that I have used during the course of writing this research report have been fully credited and acknowledged. Furthermore, this research report has not been submitted for any academic or examination purpose at any other university.

Name

Signature

Date

DEDICATION

This work is dedicated to my daughter Kate van Niekerk and to the memory of my brother Keith Sidley who having supported the venture, squeezed a commitment from me within days of his death, that I would complete it.

ACKNOWLEDGEMENTS

I owe the University of the Witwatersrand a large debt of gratitude for making this course possible for me and then surviving my erratic attempts at actually completing it. Those particularly in the Health Sciences Faculty and its Post graduate office, have added immensely to the university's role of enriching the lives of most members of my immediate family in a variety of ways.

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My parents Arnold Sidley and Jeannette Molly Sidley (nee de Saxe) supported me through the course, while my brother who was living in Los Angeles encouraged it by constant badgering and "motivational" chats. Both my father and brother died during the period but my mother, whose own career had its origins as Professor Raymond Dart's secretary, and for Prof Phillip Tobias among others, has put aside her own needs so that I may complete the work. My sister-in-law Kathleen Nolen in the United States knows how much I have relied on her. Without all the doctors and journalist colleagues I have worked with or consulted I may never have formed the specific interest in this report nor had the fun I needed for survival.

ABSTRACT

This research report tells the story of a doctor and a journalist who, at the height of Apartheid's State of Emergency, placed themselves at risk for the sake of practicing their professions ethically. They chose to defy the law, and bring to the attention of the public, the plight of many detainees who suffered at the hands of the State. In the report, I set out to give an account of the events and to ethically reflect on the actions of the two professionals involved. In particular, I consider the role played by professional codes of conduct in the actions of the two professionals and I reflect on the notion of trust as a centrally important ethical conception with respect to the events described.

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1. INTRODUCTION

This research report uses an incident, which occurred during the last years of Apartheid as a case study to reflect on the concept and meaning of trust. It involves a reflection on how trust was perceived and enacted upon by a doctor and a journalist when caught up in the mechanisms and mayhem of the Apartheid apparatus. By necessity, it also concerns the public. This is because the turmoil resulting from the uprising of the disenfranchised black majority and the ensuing crackdown on them by the Apartheid apparatus was widespread. In this complex setting, "trust" was at a low ebb among South Africans, generally. In examining the case, I acknowledge the influence of how context influences ethical/legal choices.

The case involves a doctor who treated many young political activists who had been detained by the Apartheid authorities under security legislation in place at the time. As he began to see more and more cases of detainees who had been mistreated, assaulted and tortured, he started to document them. Despite draconian legislation intended to prevent publication, which would expose the human rights violations he witnessed, the doctor chose to take a journalist into his confidence. Eventually they decided to defy the intention of the press restrictions of the time and to publish what he knew. This brought both the doctor and journalist into conflict with the law and both faced very serious legal consequences.

My interest in the circumstances of the case study arose as a result of several factors, which influenced the way in which I saw events at the time and see them still. My

experiences as a journalist during the end of the Apartheid era, and as an observer and occasional participant in the described events, had a large and undeniable influence on my interpretation of the events I describe in this report. For much of the time I worked as a journalist, and until the end of the Apartheid era, I was an office bearer of the Southern African Society of Journalists (a trade union). For three years of that time, I was its first woman president. This gave me good insight into the dynamics of being a journalist at that time and into the ethical dilemmas associated with working as a journalist in that context. I also had some personal involvement in the case I describe, as I was a patient of the medical doctor at the centre of these events, Dr Paul Davis. Davis apparently had a number of Johannesburg's journalists as patients. One of those was Jo-Anne Richards. This research report is centered on these two professionals and on their moral choices in the context of the time.

1.1. Rationale

My intention in this research report is to give an account of how two professionals responded to ethical challenges they confronted. These events have not been documented before, outside of current newspaper reports, so it is important that the story should be told. It is also important that the events should be reflected on ethically. This is even more pertinent in the current context in South Africa, where challenges to freedom of speech and of the press have again begun to emerge. Persistent threats to regulate the media by the current government — and legislation, such as the Protection of State Information Act — constitute new threats to press freedom. It seems timely to reflect on the past in this context. Professionals could once again find themselves facing ethical dilemmas similar to those faced by Davis and Richards.

1.2. Objectives

The objectives of this research are:

- To give an account of the actions of a doctor and a journalist in response to ethical challenges they faced in their historical and political context.
- To consider the role played by professional codes of conduct in the actions of the two professionals.
- To ethically reflect on their actions.
- To reflect on the notion of trust as a centrally important ethical conception with respect to the events described.

1.3. Methodology

This research report is centered on a case study. It is essentially an exploration of some of the important ethical considerations arising out of the events recounted in the case study. As such, it is mainly philosophical and normative, seeking to reflect on the ethics inherent in the case. The standard methods of a normative study are, therefore, applied. This primarily involves the interpretation and critical analysis of salient texts. My critical analysis of relevant texts involves the definition and clarification of concepts, the identification and criticism of assumptions, the analysis and evaluation of theoretical frameworks, the development and defense of arguments, the use of counter-examples, and the articulation of the most plausible interpretation of significant concepts found in the sources. Most of the research involved was library-based and desktop research. However, in order to give an account of the actual events, as well as of the motivation and experiences of Davis and Richards, I interviewed both of them. The interviews were semi-structured and intended mainly to obtain their personal perspectives on the events and clarify some historical details. This constitutes the only new empirical research in the study. It is important, however, because it provides a novel historical account of the

events, as well as insight into what the two professionals thought at the time and why they acted as they did.

1.4. Ethics considerations

An ethics waiver was obtained from the Human Research Ethics Committee of the University of the Witwatersrand to interview Davis and Richards. Their written consent to be interviewed and for this research to be included in this report was obtained.

1.5. Overview

After this introductory chapter, in chapter 2, I give an account of the actual events at the centre of this case study, as well as of the historical context in which they occurred. In chapter 3, I consider the role of ethical codes of conduct for doctors and journalists. In chapter 4, I explore the notion of trust and its significance in this case. In chapter 5 I make some concluding remarks.

2. THE CASE STUDY

In this chapter, I consider the case study itself. Based on personal interviews with the two professionals at the centre of this historical incident and my own recollection of the events of the time, I give an account of the events that took place. I also briefly sketch the historical context in which the incident took place.

The case study in this research report involves the actions of two people: Dr Paul Davis, a doctor in private practice, and a journalist, Ms Jo-Anne Richards, then employed by *The Star* – a Johannesburg newspaper. It took place during a State of Emergency declared by the South African government. Both Davis and Richards were interviewed about the events and their motivation for the action they took.

2.1. The context of the State of Emergency

A partial State of Emergency was declared by the government on July 21, 1985 and lifted on March 7 the next year (*Proclamations R120-R121*, *Government Gazette 9876-9877* and *Gazette notice 1674 Government Gazette 9878* and *Proclamation R3 Government Gazette 10119*) (Merrett, 1994). In his book *A Culture of Censorship. Secrecy and Intellectual Repression in South Africa,* Christopher Merrett commented that the reasons for the timing of the emergency laws were open to speculation but he quoted the government stating that the purpose of the Emergency was "normalisation" (Merrett, 1994: 113). "The most important characteristic of the Emergency regulations was the lifting of curbs on police conduct: … they continued to dispose of their opponents by violent means" (Merett 1994: 113).

> The central feature of the security regulations is the power of any member of a 'security force' (defined to include the South African Police, the South African

> Defence Force and the Prisons Service) to arrest without warrant any person 'whose detention is, in the opinion of such member, necessary for the safety of the public of the maintenance of public order, or for the safety of that person himself or for the termination of the State of Emergency' (Marcus, 1988: 456).

The law used to accomplish this was the *Public Safety Act 3 of 1953* (Bell Dewar and Hall, 1990: 281-290). A plethora of regulations, in which further restrictions were imposed to supplement already tough security measures, was published at the same time. This allowed, among other measures, for the detention without trial of political activists. Many of these were young individuals. Some 32 000 people were detained under emergency regulations between June 1985 and September 1988 (South African Institute of Race Relations, 1989: 552).

The emergency regulations were, however, largely aimed at seeing to it that information about the security crackdown — which could be accomplished in terms of other pre-existing security legislation — was not reported in the press. As Bell Dewar and Hall (1990: 281) put it: "Under the State of emergency, severe restrictions were imposed on the press, in the form of Media Emergency Regulations – a tangled web of laws, so complex and interwoven, that it was only by the 'grace' of the various officials under whose departments the enforcement of the regulations resorted, that many newspapers are still on the streets." With long periods of detention, and what was widely accepted as treatment that amounted to torture of one type or another, the courts were frequently approached for relief, either seeking a halt to this harsh treatment, or seeking the release of detainees who had been harshly treated.

In the *South African Journal of Human Rights* Julian Riekert (1995) refers to several cases in which the courts of the time did not accept evidence from a prisoner or detainee claiming torture or mistreatment by the police. Referring to the United States case, *Miranda vs the State of Arizona* 384 U.S. 436 (1966), he concludes that the interrogation methods often amounted to torture. Furthermore, these incidents took place privately and this meant that the public was unable to be sure of exactly what went on. Riekert points to judgments in court proceedings of the time, in which the fact that a detainee was tortured in prison was not contested, but the judgments nevertheless did not apportion blame to anyone in particular, as there was no evidence as to exactly who had inflicted harm on the prisoner or detainee (Riekert, 1985: 245-50),

2.2. The actions of Davis and Richards

It was within this context that a Johannesburg general practitioner in private practice, Dr Paul Davis, along with other doctors, took action to oppose the system of Apartheid and the forces it relied on to perpetuate itself. In particular, he opposed the actions of the police, which resulted in severe health consequences for prisoners and detainees. Comparatively few doctors, however — a "handful" according to Davis during an interview with the researcher — were doing much about this. By 1987, Davis had begun to record the clinical condition of detainees as they were released and brought to him for treatment or examination. Davis's practice had both journalists and activists as patients, which helped to enable what then unfolded as he told of the events.

As the numbers of detainees showing signs of severe abuse at the hands of the police and prison staff while in prison grew, Davis told a reporter about some of his experiences. This was Jo-Anne Richards who, at the time, was employed at *The Star*, one

of Johannesburg's larger daily newspapers. *The Star* had a wide readership, both black and white. It was one of several papers around the country owned by the then Argus Group, which was, in turn, owned by Johnnic Ltd (which owned South African Associated Newspapers Ltd), which, in turn, was owned and controlled by Anglo American. The companies were listed on the Johannesburg Stock Exchange, had shareholders, and were thus expected to make profits for those shareholders. This presented the newspaper and Richards with the need to perform a fine balancing act of not breaking the increasingly repressive laws and censorship regulations, while still remaining credible to its differing audiences, and making a profit for shareholders.

In June 1986 the government had imposed another State of Emergency, this time with specific media restrictions to better target the communication and information sectors (Merrett, 1994: 114). "For weeks people disappeared into detention or hiding, meetings were paralysed by uncertainty about what could or could not be said (even in the form of prayers), political organisations were forced underground, and the publication of anti-Apartheid opinion and news was stifled" (Merrett, 1994: 114). Newspapers were heavily censored. Richards had noticed that, while many detainees had approached the courts for redress for harm they said had been done to them, this action seldom succeeded.

Davis continued to see patients who had been detained and who showed signs, to a greater or lesser degree, of torture. All his detainee patients "to a man, had signs of post traumatic stress disorder" aside from other signs of physical abuse, he said (Paul Davis, Interview). Davis wished for this information to be exposed, with a view to stopping the systematic abuse. The Emergency Regulations ensured that little was known about detainees including such details and who they were and where they came from. Non-Governmental Organisations (NGOs) and political movements such as the United

Democratic Front and the Detainees Parents Support Committee (DPSC) were seen as a problem by the government. NGOs such as the DPSC sought to highlight the detainees' plight and place pressure locally and abroad on the South African government about human rights abuses. "The years 1987-1988 have gone down in activist memory as marking the depth of despair" (van Kessell, 2000: 42).

Davis approached several organisations in the hope of joining forces with them to expose the situation, but none were forthcoming. According to him, these included the Medical Association of South Africa (MASA) and the National Medical and Dental Association (NAMDA).

Support groups, such as the Detainees Parents Support Committee (DPSC), were formed for detainees and their families (South African Military Health Service, 2009: 389). The DPSC also offered services like medical and psychiatric treatment. "As the links between ill health and detention became more obvious, multidisciplinary teams of health professionals were organized to provide services to survivors" (South African Military Health Service, 2009: 389). According to *The Military Health History* (2009) several groups of doctors saw detainees and findings were presented at various meetings. But in 1985, Davis prepared another report in which, for the first time, physical evidence of torture of ex-detainees was documented.

As the numbers of detainees showing signs of severe abuse at the hands of the police and prison staff while in detention grew, Davis described his findings and his frustrations to Richards, the journalist at *The Star* and his patient at the time. Richards explained in her interview that she had noticed the worrying trend of cases of alleged torture that came to court, but which did not succeed. Davis's dossier and his discussing it with her

gave her the opportunity to ask her editor if the *Star* would publish the evidence Davis had collected, to prove that detainees were indeed being tortured. Her editor agreed. There was one proviso, and that was to keep Davis's name confidential to protect his patients. The publication of such a story would alert readers to systematic and routine torture of detainees, something that both Richards and Davis realized the government would not want to see.

There were considerable risks in running a story such as that which Richards intended publishing. Among these were denials that detainees were being abused at all, and the simultaneous counter-accusation that those who complained were agents of foreign powers or "godless communists". The Emergency Regulations provided a vacuum of information into which the government could place its version of events. "Government pronouncements plumbed the depths of double-speak which would have provided George Orwell with inspiration…" (Merrett, 1994: 115). Information was blatantly manipulated and distorted (Merrett, 1994: 115). The situation was made even more tricky, because of the great difficulty in proving the torture of detainees in court. Versions of the events provided by police and prison authorities were often backed up by District Surgeons, whose task it was to attend to the health needs of prisoners and detainees, and who, as state employees might have prioritised their loyalty to the State over the interests of their patients (Riekert, 1986: 49-59).

The requirement of Davis that his name be kept out of the story, raised the risk of the newspaper and its journalist being required to give his name in terms of Section 205 of the *Criminal Procedure Act*. A breach of the media regulations of the Emergency regulations could mean jail for the journalist (Bell Dewar and Hall, 1990: 283 – 285).

Asked about Richards's motivation for the publication, she said she believed the information had to be "out there", as so many had claimed to have been abused. This would not be mere allegation, it would be proof. People reading the newspaper would believe that this provided the proof.

2.3. The response of the authorities

The day following publication, the police arrived at the offices of the *Star* with a subpoena in terms of Section 205 (1) of the *Criminal Procedure Act* 51 of 1977. Richards was to either tell the police the name of her source or appear before a magistrate and disclose the information there, or face imprisonment. Known to journalists, then as now, as "Section 205", the law prescribed that anybody knowing certain details about the commission of a crime would have to give the needed information to investigating officers. Journalists were not legally protected from this, despite the requirement to protect the confidentiality of sources being basic to most codes of ethics for journalists and, in particular, to the Code of Ethics the Southern African Society of Journalists Union, a union to which Richards belonged. Non-compliance meant risking a long jail term, which could be repeated indefinitely, if necessary, as the term ended and the reporter was asked the same questions again. The Criminal Procedure Act 51 of 1977, Section 205 (1) dealt with the investigation of a crime and stated: "A magistrate may, upon the request of a public prosecutor require the attendance before him or any other magistrate, for examination by the public prosecutor, of any person who is likely to give material or relevant information as to any alleged offence, whether or not it is known by whom the offence was committed."

Section 189 (1) stated:

> If any person present at criminal proceedings is required to give evidence at proceedings and refuses to be sworn or to make an affirmation as a witness, or, having been sworn or having made an affirmation as a witness, refuses to answer any question put to him or refuses or fails to produce any book, paper or document required to be produced by him, the court may in a summary manner enquire into such refusal or failure and, unless the person so refusing or failing has a just excuse for his refusal or failure, sentence him to imprisonment for a period not exceeding two years.

Moreover, if the alleged crime happened to fall within the scope of the *Internal Security Act*, 1982 (Act 74 of 1982), the sentence could be up to five years (Bell Dewer and Hall, 1990: 261). Again, if the person convicted under these conditions still refused to give the information, whether or not she had it, at the end of the period of incarceration, the same procedure could be repeated along with the sentence.

The trickiness of the situation was exacerbated because of the great difficulty involved in trying to provide proof of the torture of detainees in court. Versions of the events provided by police and prison authorities were often backed up by District Surgeons, whose task it was to attend to the health needs of prisoners and detainees, and who, as state employees might have prioritised their loyalty to the State over the interests of their patients (Riekert, 1986: 49-59).

In terms of the subpoena requiring Richards to identify her source, a crime had to have been committed. In this case, the authorities claimed that they wanted to investigate the crime police had allegedly committed in the form of assaulting detainees. This required that Richards disclose the doctor's name in order for the police to be able to investigate

and address the "crime". Richards appeared before the magistrate, but declined to give the name. She was ordered to appear again, but shortly before her next appearance, Davis came forward, and made it known that he had supplied the information. This allowed Richards to give the name and not face prison. She said she did so with a heavy heart as she worried that the police spotlight would now fall on Davis and his detainees – which it did.

Davis was then served with a Section 205 subpoena and was asked to hand over the names and files of his patients who had claimed they had been abused. Again, police said they wished to investigate the crime of bringing harm to the detainees. Davis would not comply, but arranged instead with the Detainees Parents' Support Committee (DPSC) to bring former detainees who were willing to testify to their torture to the police. The police refused this offer, according to Davis. Davis declined to give the evidence to the magistrate on the grounds of medical confidentiality. This forced the hand of the magistrate who found against Davis, who then appealed to the then Supreme Court of the Witwatersrand Division. During the appeal, within 12 minutes after the ending of argument, said Davis, the court gave its ruling and turned down his appeal. This meant that Davis would have to face the magistrate and state that he would not turn over the names and identities of his patients.

On his telling he bade his family farewell on the morning he was to face the magistrate with the thought that he may not see them for a while. In the interim however, the files had been moved and hidden, many given back to the patients themselves and some destroyed, he said. This meant he could confidently tell the magistrate he no longer had the files – which he did, thereby avoiding imprisonment.

2.4. The ethical motivation for the actions of Davis and Richards

Davis and Richards did not only face security legislation and regulations, they were both bound by ethical norms. Richards, as a reporter, had given her word she would not disclose the identity of her source, and Davis, in turn, did not provide any identifying data that might imply he had disclosed patient records, which could identify individual patients.

Davis mentioned specifically in the interview that he had taken the Hippocratic Oath, while studying to be a doctor, and felt bound to carry out its requirements. This meant assisting his patients as well as keeping their identities confidential. Richards, by the same token, was bound by ethical considerations. She, too, was bound by rules of confidentiality and she had assured Davis she would not disclose his identity as her source of the published information. She was also aware that this could see her sentenced to indefinite jail terms. She had felt a tremendous guilt, she said, when Davis came forward and disclosed his role in the saga to prevent her from going to jail.

For Davis, it meant that the long-held belief that doctors protecting patients' confidentiality was protected by law, would be tested. His attempts to convince two magistrates and a full bench of the then Supreme Court that doctors should not be penalized for keeping their patients records confidential, fell on legally deaf ears.
The consequences for the trust underlying doctor-patient confidentiality would have been another casualty, were it not for the fact that he could tell the magistrate that he no longer had the records.

The whole incident raises several questions, some of them concerning the ethics of the conduct of both the doctor and the journalist. Many of those ethical points are contained in the respective codes of ethics that effectively bind doctors and journalists to certain types of ethical conduct. But the questions go deeper than that. Among the many which will be examined in this report is the question of why they behaved in the way they did.

More puzzling was the behaviour of those other professionals who did not behave in the same way, either by silently staying out of harm's way (as they may have seen it) or by tacitly supporting the view that the then government was forced to take action to suppress an armed uprising and believing that the system they effectively supported was neither evil nor wrong.

3. CODES OF ETHICS

In this chapter, I turn my attention to the codes of ethics governing the medical and journalist professions. I identify items in these respective codes that were of relevance to the two professionals during this incident, and I tease out the significance of these.

Codes of ethics serve as a basic reference point for trustworthy behaviour among professionals. Both doctors and journalists believe themselves to be bound by codes of ethical conduct. These codes are often taken to be the basis for a social contract between the professions and society, in which the professions are granted considerable autonomy to regulate their own members and enforce ethical standards (Cruess et al, 2004: 75). The different codes among doctor groups and countries have many basic points in common. This is the case with journalists and their codes as well. One major difference will always be the manner and degree of enforceability of the codes between the professions and the systems provided for sanctions where there is a breach. In medicine, in the main, many of the points in codes of ethics will have the force of law behind them, with quasi-legal sanctions if there is a breach. Among journalists' groups, that would almost invariably be seen as interference by the government in the work of the journalist, and would be opposed. The codes are a visible assurance to the public that, when adhered to, the members of each profession can be trusted by members of the public. The professionals in turn, rely on that trust so they may effectively do their jobs.

Among the points that codes for doctors and journalists will almost always have in common, is the requirement that harm that can be avoided will not take place, and certainly will never be perpetrated intentionally. For both doctors and journalists confidentiality has to be assured. The World Medical Association lists under "Duties of

Physicians to Patients" that a physician shall "respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can only be removed by a breach of confidentiality".
[http://www.wma.net/en/30publications/10policies/c8/index.html].

Similarly, the International Federation of Journalists (IFJ) — the IFJ is an international body made up of journalists' trade unions from around the world — says in its "Declaration of Principles on the Conduct of Journalists": "The journalist shall observe professional secrecy regarding the source of information obtained in confidence" [www.ifj.org/en/pages/journalism-ethics].

To disclose details of a patient's condition unnecessarily would also mean the doctor and perhaps others, would not be entrusted with information easily. In the case of a journalist, although identifying a source may lend more credibility to a news story, the consequences for a source whose confidentiality is not respected may be that the source could lose a job, end up in jail, or be placed in a situation of possible harm. More broadly, both the journalist and the employing newspaper would lose public credibility and trust, if confidentiality was breached.

Central to all codes of ethics are provisions designed to build or preserve trust. In a conflicted or divided society, one might hope that the codes transcend differences and offer guidance through complex ethical dilemmas. That does not, however, always appear to be the case.

Among the pertinent ethical issues that might arise are questions concerning what a doctor or journalist should do when unjust laws are encountered, or what relationship, in general, the doctor or journalist is to have with the law of the land, (not necessarily in respect of unjust laws) where there may be differences of approaches. While some codes carry an injunction to the professional to advocate for the profession, their patients or clients, some do not. Some international conventions and agreements, themselves often codes of conduct, were drawn up in the main to ensure that, during times of conflict and war, professionals do not become complicit in wrongdoing perpetuated by the State or other parties involved in the conflict.

In medicine, many of these codes were drawn up after World War II, but despite their having been in existence for some time, there have been examples in conflict situations since the acceptance of these codes that illustrate that many breaches of these codes still occur. Some well-publicised examples include wars and conflicts in Iraq, the Middle East, and internal conflict resulting from Apartheid in South Africa (Gaetta 1999: 173-174). A strong argument can be made that in most societies where a powerful elite (which may be a minority) exerts power and influence over others, the same breaches in codes of professional conduct can be witnessed. Breaches of ethical codes cast a shadow over the trust relationships, and may result in such low levels of trust that large groups of people end up being excluded from medical care. Or, in the case of journalism, a group of people may "disappear" to all intents and purposes, from the public radar screen, as journalists either willingly collaborate with authorities by not telling their stories or are intimidated or constrained to do so. These groups easily become disempowered and marginalized by the black-out of information they may need or would want to have made public.

In many cases where doctors have collaborated with authorities in human rights abuses, such as the torture or other inhumane treatment of prisoners or enemy soldiers, these actions have been justified on the grounds that the doctors were merely following orders (Gaeta, 1999: 173). The notion that such actions by doctors can be condoned on these grounds is at best simplistic and at all times, in breach of international guidelines, such as the Declaration of Tokyo (World Medical Association, 2006). For example, although the attempt has been made to justify maltreatment of prisoners in Iraq, there are few outside of the decision-makers and participants of the policies, who would not say it was torture and unjustifiable and that doctors should be prohibited from participating in such treatment. The first point in the Declaration of Tokyo reads: "The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the office of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife" (World Medical Association, 2006)

Articles concerning doctors' complicity in torture and other abuses were published globally at the time the events at the centre of this report took place and several times since then, giving rise to a widespread criticism of the practice, and prompting questions of trust of doctors in the scenario and in journalists writing about it. We can see the links to the case of Davis and Richards, which highlight questions of trust and adherence to ethical codes. An obvious question to ask is whether they were influenced by their respective Codes of Ethics. Both said, in their interviews, that they were influenced in this way.

In the following section, I briefly refer to and comment on some relevant aspects of the codes of ethics that would have been applicable to Davis and Richards at the time. In the section after this, I consider how their actions were likely influenced by these codes.

3.1. Codes of Ethics

3.1.1. Codes of Ethics for Doctors

The World Medical Association *International Code of Medical Ethics*, as amended at the 57th WMA General assembly, Pilanesberg, South Africa, October 2006 (http://www.wma.net/net/en/30publications/10policies/c8/index.html) says the following among other points:

> A physician shall always bear in mind the obligation to respect human life.
>
> A physician shall act in the patient's best interest when providing medical care.
>
> A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her.
>
> A physician shall respect a patient's right to confidentiality.
>
> A physician shall give emergency care as a humanitarian duty.
>
> A physician shall always exercise his/her independent professional judgement and maintain the highest standards of professional conduct.
>
> A physician shall respect a competent patient's right to accept or refuse treatment.
>
> A physician shall not allow his/her judgment to be influenced by personal profit or unfair discrimination.
>
> A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.
>
> A physician shall certify only that which he/she has personally verified.

A physician shall respect the local and national codes of ethics.

The Health Professions Council of South Africa (HPCSA, 2008: 2) sets out 13 "core ethical values and standards required of health care practitioners" in one of its booklets dealing with ethical guidelines for medical practitioners. These include

* Doing no harm – not acting against the best interests of patients
* Doing good – acting in the best interests of patients at all times
* The autonomy of the patient should be recognized and this should include acknowledging patients' decisions to make informed choices
* Practitioners should observe patient confidentiality and regard the truth and being truthful as part of the basis of trust in the relationship between the patient and doctor
* The right of patients to have different ethical beliefs should be respected.
* There are some points among the core ethical values, which are likely to have derived from conduct during Apartheid's excesses. These stress the need for doctors to observe human rights, tolerance and justice.

The codes above are not comprehensive, but show the similarities among many of the main points. These codes would be supplemented by international declarations and professional guidelines like the Tokyo (World Medical Association, 2006) or the Geneva Declarations and various similar looking documents that attempt to bind governments – like those emanating from the United Nations. Such codes do not resolve individual dilemmas, although they may give some guidance to resolving issues.

This is expressed by Selvan (writing about the situation of District Surgeons at the time) in the *South African Journal on Human Rights*. He asks: "What is a doctor to do when there

is a conflict between his ethical and moral duties on the one hand and the law of the land on the other? The answer, it is suggested, is that 'it depends'" (1986: 219). He continues:

> One such conflict concerns the doctor's obligations to keep secret information which has been conveyed to him by a patient in confidence and the requirement by statute or by a court that he divulge such information. Some journalists faced with a similar dilemma have elected to undergo imprisonment rather than break a confidence….An extreme example of this problem is where the law of the land requires or allows wickedness of the kind that took place in Nazi Germany. Then, surely no individual, so much less a doctor may seek to excuse his complicity in evil-doing by saying that he was compelled thereto by law" (Selvan, 1986: 219-220).

Doctors' codes of ethics and those of journalists have some important points in common – as illustrated by Selvan above. The mechanism of binding doctors and journalists to codes, however, are different with doctors facing possible legal action if they violate certain elements in their codes. Journalists may be forced by dint of employment contracts to adhere to certain ethical codes or codes of conduct. In general though, journalists are more likely to feel bound by codes they have drawn up themselves, often within a trade union.

Notwithstanding this, debates about the codes in a time of civil and political strife towards the end of the Apartheid era, for both doctors and journalists were hotly argued and frequently published, sometimes emerging in court proceedings. Some of that type of argument is part of the pith of this research. It needs, however, to be narrowed sufficiently to capture factually the essence and accuracy of some of the dilemmas.

3.1.2.Codes of Ethics for Journalists

The majority of codes of ethics for journalists in South Africa have been drawn up by individual employers or by employer bodies. However one that was drawn up by journalists in a trade union was that of the Southern African Society of Journalists (SASJ), which later changed its name to the South African Union of Journalists, and is now defunct. In her interview, Richards confirmed she was a member of the SASJ and felt bound by the organisation's Code of Ethics.

Retief identifies that journalists, who were members of the union, codified their ethical duties as:

- Defending the principle of freedom of the press and other media in relation to the collection of information and the expression of comment and criticism;
- Striving to eliminate distortion, news suppression and censorship and to ensure that the information he/she disseminates is fair and accurate, avoid the expression of comment and conjecture as established fact and falsification by distortion, selection or misrepresentation;
- Rectifying promptly any harmful inaccuracies, ensure that corrections and apologies receive due prominence and afford the right of reply to persons criticized when the issue is of sufficient importance.
- Obtain information, photographs and illustrations only by straightforward means. The use of other means can be justified only by the overriding consideration of the public interest. The journalist is entitled to exercise a personal conscientious objection to the use of such means.
- Doing nothing which entails intrusion into private grief and distress subject to justification by overriding considerations of public interest; and
- Protecting confidential sources of information;

- Not accepting bribes, nor shall he/she allow inducements to influence the performance of his/her professional duties;
- Not originating material that encourages discrimination on the grounds of race, colour, creed, gender or sexual orientation (Retief, 2002: 240-241).

The SASJ was affiliated to the International Federation of Journalists (IFJ), as was the union known as the Media Workers of South Africa (MWASA), which represented black journalists at the time. The IFJ represented the journalists' unions of countries globally, which were independent of governments and subscribed to similar basic principles. Its code was similar to that of the SASJ, with a first clause which read: "Respect for the truth and for the right of the public to truth is the first duty of the journalist" (International Federation of Journalists, n.d.). But the IFJ code – printed on each of its press cards which members of member unions could hold – dealt strongly with one issue not dealt with by the SASJ.

"Every journalist worthy of that name deems it his duty faithfully to observe the principles stated above. Within the general law of each country the journalist recognizes, in professional matters, the jurisdiction of his colleagues only; he excludes every kind of interference by governments or others" (International Federation of Journalists, n.d.).

3.2. The Influence of Codes of Ethics on Davis and Richards

When Paul Davis became a doctor, he would, in his early years, have attested to a statement, which had its origins in the Hippocratic Oath. Later he would have been bound by the ethical guidelines set out by the then regulatory authority, the South African Medical and Dental Council (SAMDC), now the HPCSA, which had the effect of being legally binding. This is because the SAMDC was a statutory body in terms of

the Health Professions Act, 1974 . This Act, then as now, sets out the legal powers of the Council.

Davis said, in his interview, that he belonged to a voluntary association of doctors known then as the Medical Association of South Africa (MASA), which in turn belonged to the World Medical Association. Some doctors in the thick of trying to cope with the effects of Apartheid and its security forces on the disenfranchised majority of people in the country, found themselves forced to set up an alternative organisation which was intended to better reflect the clinical and ethical demands they faced giving adequate care to their patients. This was the National Medical and Dental Association (NAMDA). Davis said he joined this organization as well – giving another dimension to what may have guided his conduct and offered moral guidance at the time.

Jo-Anne Richards was at the time employed by *The Star* newspaper, which as part of the then Argus Group, had a number of agreements in place with various bodies which regulated or guided the professional conduct of their journalists. For instance the *Prisons Act* 8 of 1959 and the *Police Act* 7 of 1958 both made provision for journalists doing their jobs, by setting up agreements between prisons, police and newspapers, which effectively set boundaries to what could be covered and published and by whom. Journalists employed by newspapers which were part of the system of agreements, were bound by its codes of conduct.

Jo-Anne Richards, however, confirmed that she also belonged to the Southern African Society of Journalists – a trade union and professional organization, which had its own Code of Ethics. She also belonged, through her membership of the SASJ, to the IFJ

with its Code of Ethics and which provided an environment for voluntarily entering into and upholding ethical and other professional standards.

Importantly, however South African journalists were far from united in their approach.. Afrikaans-speaking journalists, employed in the Afrikaans media, aimed at Afrikaans audiences, were forbidden to belong to unions. Black journalists formed another union – the Media Workers Association of South Africa (MWASA) – having at first been disallowed as members of the SASJ in its early years (the union's history had gone back to the 1920s). Only within the two decades before the imposition of the State of Emergency had it changed its policies. It deregistered as a union in order to facilitate a non-racial membership, but failed to attract many black members. The SASJ was, in labour law parlance, "recognised" at *The Star,* which meant it had as its members a majority of journalists and negotiated on behalf of them.

One could draw the inference that a form of trust (which may have excluded the journalists spying on their colleagues on behalf of the police) existed among work colleagues, which gave an unspoken understanding of how they all operated in their respective contexts. They also had an understanding of the audience for whom they were writing, for example, which part of the public it was that relied on the news they would get from these journalists. That was another basic form of trust. Overtly binding them were the SASJ (later the SAUJ) Codes of Conduct.

4. ROLES OF TRUST

In this chapter, I explore the notion of trust and its central place in the relationship between doctors and their patients, doctors and the public, and journalists and their sources, as well as journalists and the public. Drawing on the particulars of the case study, I tease out some of the complexities of what trust means in such professional relationships in so fraught a context as that which pertained in South Africa at that time.

4.1 Trust in Doctors

We – the public and individual patients – need to trust doctors. Doctors in turn, need that trust to work optimally. The nature and extent of trust can vary according to prevailing circumstances. Alfred I. Tauber, in his book *Patient Autonomy and the Ethics of Responsibility* (2005: 158) argues, in part, that trust can become a casualty of a consumer approach to patient autonomy. He believes that the movement towards greater patient autonomy is connected to, and can result in, what looks like a consumer/provider transaction as opposed to a patient/doctor relationship. More pertinently, I would argue that trust is unlikely to be present in circumstances similar to those in which Davis and his patients found themselves. The patients had previously been in detention at the hands of the police and prison staff. Davis had remarked that they had all been abused or tortured, and any doctors who had tended to their wounds or other medical needs in the prisons or police stations, would have been District Surgeons who were, like the police, employees of the State. As such, I would suggest they could be seen as complicit in the unfortunate circumstances of the detainees. Importantly, the detainees were almost all black, and the District Surgeons, white. The particular racial complexion of the patient/doctor relationship was not dissimilar to that of public hospitals with black patients and white doctors – as many were at the time. It stands to reason that the

relationship would suffer from an imbalance of power between the doctor and patient as well as an imbalance of knowledge. A missing element would be trust.

This would be in spite of institutions, laws and various other tools used by societies to assure the public that trust in doctors is deserved. Here I refer to such institutions as the then South African Medical and Dental Council, which was the statutory body regulating the behaviour and standards of doctors, or the then Medical Association of South Africa (now the South African Medical Association) (SAMA), which is a voluntary body to which doctors belong. Devices which could be used to reassure the public mind would include codes of ethics. Little of this is likely to count for much if a detainee is tortured or abused in some other way.

Outside of the prison setting, it would be expected that when patients tell their doctors things that are privileged, the doctors should be worthy of the trust given to them and should honour their duty not to break confidentiality. Doctors and schools of medicine are often regulated so as to ensure appropriate standards in the training of doctors, including holding them to certain ethical standards. These systems also regulate who may practice medicine in any given place and/or specialty. This is done as a function of building and keeping public trust in a health system and, in particular in its doctors. Trust underpins the very nature of the expectations that the public has of health care.

This is well illustrated in the title of Laurie Garrett's book *Betrayal of Trust.* (2000), which describes and analyzes the global decay and collapse of public health. It is called Garrett's work seeks to robustly defend the importance of the need for the public to be able to trust health care systems and doctors. While detailing and analysing her encyclopaedic global sweep of decay and betrayal in healthcare, Garrett justifiably assumes that the

public, as users of the healthcare system, had reasonable expectations of a certain standard of health care and trusted that the system would ensure that this standard was met. Their expectation was that they would get better health care, and that better health care was owed to them. Since this did not occur, Garrett is right in seeing this as a betrayal of legitimate trust. She points to public health systems delivering care in fits and starts and often not delivering care at all (Garrett, 2000).

Looking at the situation for journalists one could consider Garrett (whose book is referenced above) who like Jo-Anne Richards, had been a journalist. She was a Pulitzer prize winner, with a scientific academic background, and had experienced the type of trust Richards would have relied upon: that of the general public, or readers, buying newspapers, and who were likely to believe what they read. Journalists rely on their credibility to win that trust. In her interview Richards said that she knew of the frustration of readers who, like herself, had watched as allegations of torture of detainees were made, only to fail when tested in court. Here was an opportunity to show to readers that the allegations had truth in them. In other words, they could trust what they were reading.

In issues involving public health priorities – as in mass casualty situations, such as in chemical or biological warfare, or a large disaster or terror attacks - the public needs to be able to trust a health care system in the light of the fact that relationships between one doctor and a large amount of patients all needing treatment at the same time, may shift somewhat. This occurs because the urgent and critical nature of these situations entails that those patients with the greatest need be prioritized. Griffin Trotter claims: "The ethical ideal and more or less firmly entrenched habit in ordinary clinical medicine (OCM) is to attend to the interests of individual patients. This focus on beneficence is

regarded by some as medicine's overarching moral principle" (2007: 108). On this view, the actions taken by Davis were the morally correct actions to take, in that they were in the interests of his individual patients. Trotter distinguishes ethically between Ordinary Clinical Medicine (OCM) and Mass Casualty Medicine (MCM). The distinction he draws is between an ordinary situation, in a clinical setting between a doctor and patient, and a situation in chemical warfare or a disaster in which many patients are ill or even unconscious. He sees a move away from the clinical needs of the single patient towards the "service of particular aggregate interests" in times where mass casualty medicine predominates. He also sees a need to recognise exceptions to the standard ethical norms of OCM in times when MCM applies (Trotter, 2007: 108).

It could be argued that in the situation Davis found himself, the ethical norms of both OCM and of MCM applied. Davis himself would have seen his work with former detainees as OCM – but given his later action of publishing accounts of their misfortune for a greater cause, there were aspects of MCM to be seen. Nonetheless, a desire to ensure patient beneficence is evident in his actions, even when viewed as serving the interests of a greater cause (MCM). The situation of District Surgeons working within prisons at the time would be seen somewhat differently. Since they encountered patients who bore the evidence of having been assaulted and tortured, one would have to question whether their actions (or rather, lack of any action), demonstrated beneficence in any form at all. Looking at this from a Utilitarian perspective, the "aggregate interest" - to use Trotter's phrase - would not have required the abandonment of normal ethical and moral principles or, significantly, of patient beneficence (Trotter, 2007: 108). Yet, arguably, the evidence showed that pitifully few of them rose to the moral challenge. One of the few who did rise to the moral challenge was Dr Wendy Orr, who practiced as a District Surgeon in prison in Port Elizabeth in 1985. She "came to the conclusion that

large numbers of detainees were being abused by the police and she successfully intervened on their behalf, obtaining a Supreme Court interdict restraining the police from assaulting them". Jenkins reported that a technicality prevented the issue from being investigated fully (Jenkins, 1988: 436).

To return to the central notion under discussion, Tauber writes:

> Patients, like individuals in other social roles allow themselves to fit into a structure in which they trust that their basic rights will be protected. By and large, they are concerned far less with their political or legal autonomy than with getting better…. To direct our efforts, we need a better understanding of the nature of trust between patients and their caregivers. Trust and trustworthiness are basic to each element of our discussion of patient autonomy – legal, political, psychological and sociological (2005: 157).

Tauber was, at that point in his analysis, looking at patient roles and rights largely in the United States which, he noted, had changed after the "turbulent 1960s". He went on to say: "Autonomy-based medical ethics originated when disgruntled patients and their advocates reacted against what they regarded as physician arrogance and drew on legal precedent to demand informed consent in medical practice" (Tauber, 2005: 157). That might be as a function of how people themselves responded to the "turbulent 1960s", which saw the rise of the consumer movements.

Ironically, Tauber believed that while the growth of patient autonomy was bound up in the patient-doctor relationship, trust in the relationship *per se* was breaking down.
Despite the growth of autonomy, Tauber contended that public trust in the patient-doctor relationship broke down as a result of the moves towards autonomy, instituted in

the hope and expectation by patients that their rights would be better protected (Tauber, 2005: 157).

That was in the United States, but in South Africa this analysis would not be adequate without adding the needed texture – looking at the situation in which Davis and his patients (who were former detainees) found themselves. For a slightly more adequate exploration of trust and its dynamics as it applied then, one may have to add significant political and social detail to analyse the context in which the relationships, such as they were, developed. In a divided society, polarized along racial lines, who was the public that was expected to trust this doctor at the time? What suggested to the doctor that he should expect or deserve the trust? Davis was a white general practitioner, with a much more multi-racial practice than other similar private practices in white urban areas. The detainee-patients were mainly young and black, at that point powerless, disenfranchised, poor, previously detained, and they had been tortured or otherwise harmed in prison. They had also been failed by doctors within the prison system, who were also white.

Writing about "Ethical responsibilities of health professionals in caring for detainees and prisoners" in the "South African Medical Journal" Solly Benatar says: "Clearly, under ideal circumstances the relationship between doctor and patient (prisoner or detainee) in the prison setting should be no different from that which pertains in ordinary civic life" (Benatar, 1988: 453). Trotter's views may appear to contradict Benatar's. But Trotter's view applies largely to situations of mass casualty, such as one might find in chemical warfare or a large disaster or terror attack. Benatar quotes Richard Smith who said: "The idea that prison doctors drug prisoners, close their eyes to brutality, identify with prison governors rather than prisoners, and think of prisoners as prisoners first and patients second is deeply rooted – among both the public and doctors." (Benatar, 1988: 454).

Benatar adds: "This perception of prison medicine in England also pertains in South Africa where there are up to 5 times as many prisoners per 100 000 population as in the UK and where less resources are allocated to medical care" (Benatar, 1988: 454). Citing detention without trial, particularly for children and for long periods, he maintains that the increasing use of this strategy and decreasing attention to the humanitarian needs of prisoners and detainees was "inhumane and [struck] at the foundation of the Rule of Law". This he said was worse under the emergency regulations during the State of Emergency (Benatar, 1988: 454).

In this context, brutalised young black detainees emerged and were taken to Davis's rooms. Despite the atmosphere being conducive to a lack of trust, his patients trusted him, he believed. He had described his practice as having particular types of patients – activists among them, and many of these activists were detained and returned to his practice.

South Africa was not alone in its unacceptable behaviour towards its "enemies". Nor was the behaviour confined to the times. Because atrocities have happened several times in the past, governments or an occupying power, in times of civil conflict or war have put in place various national and international agreements in an attempt to keep faith with the overriding duties of doctors which would, in theory, allow all to rely on medical assistance when they need it. This, however, seems often to be the exception and not the rule. It also appears that many doctors in an ordinary clinical setting need further training in the area.

Wendy Carlton (1978) provides an example of this. In her work she looked at how medical students through several years of their training, integrated the clinical, legal and

moral perspectives of their training. Carlton used three differing situations in clinical settings all with ethical considerations. All three needed the informed consent of the patient for treatment. These three situations involved females with differing clinical problems: one with depression, another, a young obese girl requiring a risky cardiology procedure, and the third, an elderly senile woman in renal and respiratory failure who could not communicate much of the time. These situations raised ethical questions, including competency to make informed decisions, issues surrounding the likelihood and timing of death - which was near in one case - as well as decisions on whether death was desirable or not (Carlton, 1978).

The discussions took place between the doctors, and (on one occasion) Carlton, herself, was asked how she, as a sociologist, saw things. Carlton noted that the questions raised were either legal or clinical but never "moral". These issues are all dealt with at length in the book, but the reason for exploring part of it here, is to provide her observations of doctors' behaviour. All of the responses fell within limited legal and clinical guidelines – but the ethical issues within these parameters appeared almost never tackled (Carlton, 1978).

The behaviour within the narrow confines of legal and clinical decision-making that her investigation showed up may, in turn, allow for greater understanding of the failures in some doctors, as well as the seemingly unusual performances of duty in others during times of conflict and division in South Africa at the time of the case study. Drawing a distinction between "professional ethics" as doctors would use it and "ethical issues" as the public or patients may see them, Carlton (1978: 59) says: "A corollary to the most general formulation of professional standards of behaviour is the protection of self-interest. The physician may bend or break the rules as long as he or she ensures the low

visibility of the offense by protecting superiors and patients from knowledge of purposeful deviance." On ethical issues as "non-physicians" would see it, and noting that these two views need not be in conflict, Carlton (1978: 63) writes, "…the physician tends to be blind to the ethical issues as long as the plan of management can be reduced to concrete data, derived from a professional orientation toward pathology and organicity."

Carlton's study, in the context of the case study on which this report is based, allows one to examine the setting or situation. In this way we might examine the extent, if at all, if some of the basics of "trust" might exist more easily in a society with less conflict and division than existed in South Africa at the time of the case study. For instance, the set of standards that one might assume were upheld and enforced by a regulatory body such as the SAMDC, allowed for some transparency so that standards were visible, as was, at least to a degree, the process of upholding them. In theory, these standards, including the education of doctors, were based on best practice elsewhere and were supposedly arrived at objectively.

The legal provisions that enforced segregation at all levels (except at public hospitals where no such law existed) were enshrined in a variety of laws, rules and regulations. *The Group Areas Act* 41 of 1950 set out geographical racial boundaries; and various Acts in education specified which racial group could teach other racial groups and where. This was not confined to medicine, but in the context of medicine, the transparency of standard-setting which would allow for public trust, proved a veneer as the reality of power politics lent the lie to the appearance of uniform, objective standards upheld in a similar fashion. The power of the political elite overtook and eroded the sense of trust that could be uniformly relied on by the public for the institutions of medical care

practice. It perverted the reciprocal trust of patients and the public, which formed the core of the patient-doctor relationship.

A pertinent ethical issue arises when the state determines it is necessary to overstep individual liberty for the common good, or the state's conception of what constitutes the common good. Trotter discusses when forced medical directives would be justified and when not, how legitimate force should be exercised and implemented, and what societies can do to protect themselves against excessive coercion. He also describes how trust might operate between patients and the "public manifest for clinicians and other persons involved in the provision of health care" in situations where mass casualties are not the focus. While the approach to dilemmas would be the same as in mass casualty medicine in other situations, "the loci and dynamics of trust are somewhat different" (Trotter, 2007: 15). The description that follows on these changes in trust dynamics is useful when reflecting on the case study.

Some of these issues involve the trust or lack of it between doctors and patients, between the public concerning government officials and health authorities, and how much the public, in turn, is trusted or not trusted by health care officials or the government (Trotter 2007: 21-39). To the extent that trust existed, it relied on a fiction or vacuum that may have been provided in a specific setting in which perhaps doctors and patients shared language or race or culture (or all three) in common. But, in the particular setting in South Africa, in which certain ethical challenges were posed, trust would largely have been absent or misplaced. Patients with gunshot wounds from political violence were on occasion chased into hospitals by security forces who then forced staff to hand over the patients' supposedly confidential medical records. This was done at times with the co-operation of staff but on other occasions it was strongly resisted.

Detainees who had been released described the use of confidential medical records to abuse other detainees and to identify activists for whom the security forces were looking. Much of this information came to light with the visit of various international human rights groups. The visits had been sponsored by respected institutions and sought to examine health and human rights in South Africa at the time. (Nightingale et al. 1990: 2097-2102).

Generally patients were unlikely, in those circumstances, to entrust their wellbeing to hospital settings in which they risked such security problems. Doctors were not always to be relied on either, from a trust perspective, and this was manifest most often in settings where District Surgeons were used and might have been expected, under less fraught circumstances, to tend to prisoners who were ill. One US Human Rights group reported detainees' suspicions and lack of trust in district Surgeons in prisons (Nightingale, et al, 1990: 2097-2102). This should have provoked some form of official ethical scrutiny, aimed at correcting errant behaviour, but failed to do so until the issue was forced in the then Supreme Court. This was motivated by doctors who objected to the lack of action from the SAMDC over the role of three doctors in the death in detention of activist, Steve Biko (McLean and Jenkins, 2003).

4.2 Trust in Journalists

In journalism, at the time, the nature of the conversation about trust would have differed in many respects from that pertaining to doctors, despite some similarities. The newspaper-buying public at the time was not one cohesive mass. It was divided along race, language, regional and income lines. The divisions were also expressed along political lines – which was why the press became the focus of censorship during the

National Party's rule of the country. This censorship was magnified during the State of Emergency. However, one section of the press was not the focus of this attention. Although (arguably) this section's readership was deprived of information in the same way as other readers, there was an absence of outrage or anger among them which was easy to interpret as complacency. What was common among these divisions however, was trust. It was the trust of its reading public for what was in the newspapers they chose to read.

The nature of what constitutes "news", who decides this, and who is the "public" in whose interests it will be published, all become questions to examine in this context, too. These questions, in a society with every fault line possible, require some examination to assess the ethical or other behaviour of those who published that type of story, or failed to. Newspaper sales, and, therefore, how these affected profits, were intimately connected to which racial, political and economic grouping was targeted and that, in turn, required knowing who would read what. Who was the public that journalists were claiming had an inviolate right to know what journalists selected for them as information?

In South Africa, then and now, it was far from simple to answer that question. Because these institutions had to be profitable, and advertisers brought in the lion's share of revenue and profit, systems evolved which sought to break down and analyse the patterns of purchase, reading and behaviour of readers. These are reported on, with other statistics, in the media industry "bible" known as AMPS – *The All Media Publications Survey*. The Audit Bureau of Circulation (ABC) audited sales and published these at regular intervals during the year.

The Afrikaans press and one English language newspaper – *The Citizen* – had no real quarrel with the National Party. Largely, their readers agreed with the National Party and had kept voting for it. This stand was reflected in editorial policy, leader writing and in the selection of news. The most likely explanation for their stance was that they trusted that if measures were being taken to restrict their access to information, such decisions were made necessary by the "total onslaught" of a communist revolution, nipping at the heels of law and order and had its basis in keeping a just and "good" society.

In an earlier era, during the 1960s, Brian Bunting, in his book *The Rise of the South African Reich* (1986), provided a particularly useful analysis of why it was so necessary for the National Party to have "the Control of Ideas" – the title of his chapter analysing this aspect of South African politics. He provided the circulation figures of the time, which he said were externally audited. It provides an audit and, barring a few scandals along the way, generally provides an accurate picture of sales. Dividing them into "Nationalist" and "Non-Nationalist" papers (which coincided with Afrikaans and English papers at the time), using 1962 and 1967 figures, he showed that in 1962 "Nationalist" daily papers had a total circulation figure of 166 000 papers with Non-Nationalist papers at 702 000. In 1967 these figures were 183 500 and 791 000 respectively (Bunting, 1986). As he put it, "From these figures it can be seen that when it comes to influencing public opinion through the medium of the Press, the Nationalist Party is at a serious disadvantage" (Bunting 1964:300). Bunting believed that the only way to change this was either to found rival newspapers to compete with the English Press or force the English Press to conform. In the event, the Nationalists did both -- starting with the establishment of a State-sponsored, pro-Nationalist newspaper, *The Citizen,* and instituting a regime of censorship, which attempted to force the English Press to conform. Bunting wrote the book well before *The Citizen* was launched with taxpayers' money and front companies

disguising the origins. (Merrett 1994: 88). He did not believe at the time that the National Party would opt for the alternative of starting up a paper, but said, more accurately that they would opt to control the press.

This control – with an elaborate system of censorship – became more and more necessary as the years passed and as the security forces were increasingly used to combat rising violence among the growing disenchantment of the disenfranchised majority. That disenfranchised majority was always the imponderable commodity that English newspapers showed great ambivalence about wanting to reach. This was driven by financial considerations, laced with racism, that underlay many assumptions about their readers. To be profitable, advertisers were steered to the figures of the wealthier readers, who were white. Notwithstanding this, the editorial staff judged the newsworthiness of stories that went into the newspaper in such a way that the National Party Government felt threatened with increasing numbers of black readers buying the papers.

> News needs bloodshed. Where blood is spilt, wrong-doing is not far away – and news thrives on misbehaviour. Bloodshed also excites public curiosity and horror in itself. Blood is a symbol as well as a physical manifestation, and it commands our imaginations partly because it sustains life and partly because it stands or violent death. Blood is the colour of action, health destruction and finality. News needs blood – and the disorder and nuisance its appearance in the wrong places implies – in order to display its cleansing morality (Seaton, 2005: 29).

The issue of trust in a context such as this becomes more complex, but it remains true that what appeared in papers was trusted enough by those who bought the papers as containing enough information for them to be informed about what was going on

around them. This is evidenced by the fact that they continued to purchase the papers. The National Party, however, feared that the bloodshed and violence would provide the wrong recipe to display the need for cleansing and sought to blot it out.

Despite an ambivalence by newspaper owners and managers at the time about the divisions of that readership, the journalists in the editorial sections continued with varying degrees of enthusiasm and success to provide the information relying on their news judgment, their individual integrity and credibility as journalists – and their codes of ethics. This included a healthy disrespect for the censorship measures of the time and a desire to get around them. *The Star,* therefore, in the form of its editor (then Harvey Tyson) decided to publish Jo-Anne Richards's story about Paul Davis's tortured and abused patients. This decision was accomplished by lawyers at its side to avoid large fines, jail terms or being completely shut down (all options possible at the time). The newspaper decided, by providing legal backing for Richards when it became necessary, to back what would have appeared as an illegal action, or civil disobedience, when she refused to disclose her source to a magistrate. The incident from the journalist's perspective could have been a practical experiment in trust – of the public, of the individuals, and in the ability to rely on ethical conduct whatever the consequences.

Inevitably at the time of the State of Emergency, questions arose as to what constituted "torture" and the denials by government officials that detainees were tortured were used at times to ensure cases which did land up in courts either did not succeed, or did not make it that far. Issues such as these were discussed, for example, in the *South African Journal on Human Rights*. The March 1986 issue carried an analysis of District Surgeons and detainees which, while it was written a year before the case study in question, was clearly not seen as important by prison or police officials or District Surgeons as there

was no visible change in affairs (McQuoid-Mason, 1986: 49-59). McQuoid-Mason sets out what he describes as the important role district Surgeons could play in protecting the health and welfare of prisoners. However that article was written in the absence of such protection, for example, in cases which had recently occurred, so the ill-treatment of detainees simply carried on. There were many, though, who believed they were taking the morally and ethically appropriate action (or inaction), having accepted the need for unusual activity in demanding times, by a government which had convinced itself and its followers that such behaviour was necessary and correct. A parallel to this is described in the US government's belief during the presidency of George Bush that what was effective torture, was not torture and in any event necessary to use in Iraq (Levy and Sidel, 2008: 227-239). Several international settings were used to illustrate their points but little was spoken about the lack of public trust within the USA.

Davis was a white doctor with black patients. I would contend that these patients who had suffered at the hands of mainly white policemen and women, prison staff and doctors, would not be likely to exhibit the necessary trust to assist them in getting the health care they needed. In his interview Davis said that he saw himself as one of few doctors at the time willing to take on the task of making public the torture of detainees. He remarked too, on his practice, that several of the detainees would have co-operated out of political conviction, but others, according to Davis, had been, or became his own patients. He agreed that they had trusted him. "Detainees had been detained until signs of torture had disappeared. Although they alleged torture it was hard to see. But what they all had was Post Traumatic Stress Syndrome (sic)" (Paul Davis Interview). They were frequently traumatised from the experience of solitary confinement and physical abuse, sometimes suffering from Post traumatic Stress Disorder in addition to physical scars and bruising or wounds and breaks, returning or coming into the hands of a

"privileged" white doctor. He would provide care, examine them, take a detailed history, and record the information on paper which could, in fact be used against them.

5. CONCLUDING REMARKS

In this research report I have told the story of a journalist and a doctor, who, at the height of Apartheid's State of Emergency placed themselves at risk, for the sake of practicing their professions ethically. Unlike many of their contemporaries, they chose to defy the law and bring to the attention of the public the plight of many detainees who suffered at the hands of the State. Regarding themselves as bound by their professional codes of conduct, they courageously did what they believed to be the right thing, at risk of being imprisoned for their actions.

In telling their story, I have reflected on the notion of trust as a centrally important ethical conception with respect to the events described. I have highlighted the central importance of trust in the relationship between doctors and patients, and between journalists and the public. Practicing, as they did, in a time in which trust in professionals was seriously undermined by the context of Apartheid, Davis and Richards chose to act in ways which might be thought to have gone some way towards restoring trust in their professions.

Despite the demise of Apartheid, and the end of the States of Emergency with their draconian restrictions on the media and the injustices perpetrated against activists detained under the emergency laws, South Africa today faces similar challenges. Instances of heavy-handed policing tactics employed against protesters, often leading to deaths and serious injuries are increasingly reported in the news. Government threats to more stringently regulate the press, and proposed secrecy legislation seem to threaten the

freedom of press and undermine accountability. Ethical challenges similar to those once faced by Davis and Richards may once again confront doctors and journalists in this country.

I, therefore, think that it is timely for this story to be told now. Perhaps it might serve as inspiration for other professionals facing difficult ethical challenges in the future.

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