

https://dspace.org/

The legal and ethical duty of the medical doctor to report police brutality

Jacovides, Tracy Catherine

2014-09-09
http://hdl.handle.net/10539/15455

Downloaded from a DSpace repository. https://dspace.org/

THE LEGAL AND ETHICAL DUTY OF THE MEDICAL

DOCTOR TO REPORT POLICE BRUTALITY

Tracy Catherine Jacovides

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Medical Science in Bioethics and Health Law

Johannesburg, May 2014

Postgraduate Office, Faculty of Health Sciences
Wits Medical School, 7 York Road, PARKTOWN, 2193, Johannesburg • Tel: (011) 717 2745 • Fax: (011) 717 2119 • e-mail: healthpg@health.wits.ac.za

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I TRACY JACOVIDES (Student number: 0615403N) am a student registered for the degree of MSc Med (Bioethics and Health Law) in the academic year 2013.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this in not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.

Signature: Jacovides Date: 19 May 2013

This report is dedicated to my husband Andreas (for his love, patience and encouragement and importantly, for believing in me), my children, Victoria, Gareth and Katherine (for their love and understanding) and a very special friend and mentor, Professor Edith Raidt (for listening).

Abstract

Police brutality appears to be on the increase in South Africa as revealed in the media. Statistics released by the Independent Police Investigative Directorate (IPID) seem to support this statement. This paper argues that current quantitative data used to reflect the incidence of police brutality in South Africa is unreliable. The data or statistics are based on cases that are reported and investigated. Investigations are only initiated upon receipt of a complaint (with the exception of those cases that have occurred in custody). It is argued that not all cases of police brutality are reported to the IPID for a variety of reasons, namely inadequate awareness of the complaint and reporting process, fear of reprisal or poor economic circumstance.

Since most cases of police brutality would most likely require some medical intervention, either in the form or physical treatment or psychological counselling, it is argued that the medical doctor is in a position to expose or cover-up incidents of police brutality or cruel, inhuman or degrading treatment or punishment.

This paper suggests that medical doctors can participate in an epidemiological type of surveillance where incidents of police brutality are recorded and reported. Further, the current J88 form used to report common assault or assault with intent to do grievous bodily harm can be modified based on the Istanbul Protocol, to record and document the complaint and injuries for further investigation and prosecution.

Finally, it is argued that since police brutality as a cruel, inhuman, degrading treatment or punishment is a human rights violation and in contravention of the Bill of Rights of South Africa (Chapter 2, Act 108 of 1996) that the medical doctor has at the very least, a moral and ethical duty to report police abuse.

Acknowledgement

A very sincere acknowledgement to a very special supervisor, Dr Anthony Egan, always patient, tolerant, inspirational and wise.

Table of Contents

Page

DECLARATION ii

DEDICATION iii

ABSTRACT iv

ACKNOWLEDGEMENTS v

TABLE OF CONTENTS vi

LIST OF ABBREVIATIONS x

CHAPTER 1

1.1 INTRODUCTION 1

1.2 METHOD 5

1.3 ANALYSIS 6

CHAPTER 2

2.1 CONTEXTUALISING POLICE BRUTALITY, THE ROLE OF THE MEDICAL DOCTOR AND THE EVOLUTION OF SOUTH AFRICAN MEDICAL PROFESSIONAL ORGANISATIONS... 9

2.1.1 Defining police brutality 10

2.1.2 The History of Police Brutality in South Africa 11

2.1.3 The Evolution of Health Professional Bodies and the Role of Doctors 13

CHAPTER 3

3.1 REVIEW OF GUIDELINES AND LAW 18

3.1.1 Introduction 18

3.2 CURRENT MEDICAL ETHICAL GUIDELINES 23

3.2.1 South African Medical Professional Guidelines 24

3.2.1.1 The Health Professional Council of South Africa (HPCSA) 24

3.2.1.2 The South African Medical Association 28

3.2.2 International Professional Guidelines..... **30**

3.2.2.1 World Medical Association Declaration of Geneva of 1948 (as amended) **31**

3.2.2.2 World Medical Association: Declaration of Geneva: International Code of Medical Ethics (2006)..... **31**

3.2.2.3 Declaration of Tokyo (1975) (Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention or Imprisonment)..... **32**

3.2.2.4 World Medical Association Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003, amended October, 2007)..... **33**

3.2.2.5 The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment)..... **36**

3.2.3 United Nations Statements Relevant to Health Professionals..... **39**

3.2.3.1 United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (resolution 37/194, 1982)..... **39**

3.3 HUMAN RIGHTS..... **40**

3.3.1 The Universal Declaration of Human Rights (UDHR)..... **41**

3.4 RELEVANT INTERNATIONAL LEGAL STANDARDS..... **42**

3.4.1 International Humanitarian Law and Human Rights Law..... **42**

3.4.2 The United Nations..... **43**

3.4.2.1 United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984)..... **44**

3.4.3 Commission on Human Rights..... **46**

3.4.4 Regional Organizations..... **46**

3.4.4.1 The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment..... 47

3.4.4.2 The African Commission on Human and People's Rights and the African Court on Human and Peoples' Rights..... 48

3.4.4.3 The South African Human Rights Commission (SAHRC)..... 48

3.5 NATIONAL LAW..... 50

3.5.1 The Constitution of the Republic of South Africa, (Act 108 of 1996)..... 50

3.5.1.1 The Constitution of South Africa. Chapter 2. The Bill of Rights..... 50

3.5.1.2 The Constitution of South Africa (1996), Section 35 (2) (e)..... 51

3.5.2 The National Health Act, 2003 (Act 61 of 2003)..... 51

3.5.3 Criminal Procedure Amendment Act, 2012 (Act No.9 of 2012)..... 51

3.5.4 The South African Police Services Act (Act 68 of 1995)..... 52

3.5.5 Policy on Prevention of Torture and Treatment of Persons in Custody of the South African Police Services (undated)..... 52

3.5.6 Prevention of Combating and Torture of Persons Act, 2013 (Act 13 of 2013) (sic) 53

3.6 ANALOGOUS LAW AND PROFESSIONAL GUIDELINES..... 53

3.6.1 Child abuse and neglect..... 54

3.6.2 Elder Abuse..... 54

3.6.3 Infectious Diseases..... 54

3.7 CURRENT REPORTING PROCEDURE FOR POLICE ABUSE..... 55

3.7.1 The Independent Police Investigative Directorate (IPID)..... 56

CHAPTER 4

4.1 ANALYSIS AND CRITIQUE..... 59

CHAPTER 5 ..... **77**

5.1 RECOMMENDATIONS **77**

5.1.1 Education and Training **77**

5.1.1.1 Training of medical students **78**

5.1.1.2 Continuing medical education **79**

5.1.2 The Istanbul Protocol **81**

5.1.3 Epidemiology **81**

5.2 CONCLUSION **83**

ABBREVIATIONS

AI	Amnesty International
CASAC	Council for Advancement of South African Constitution
CAT	UN Convention against Torture and Cruel, Inhuman and Degrading Treatment Or Punishment
CIDT	Cruel, Inhumane and Degrading Treatment or Punishment
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICD	Independent Complaints Directorate
IP	Istanbul Protocol
IPID	Independent Police Investigative Directorate
ISS	Institute for Security Studies
HPCSA	Health Professionals Council of South Africa
MASA	Medical Association of South Africa
MPS	Municipal Police Services
NHA	National Health Act
NGO	Non-government Organisation
No.	Number
OAU	Organisation for African Unity
PHR	Physicians for Human Rights
SABC	South African Broadcasting Corporation
SADC	Southern African Development Community
SAHRC	South African Human Rights Commission
SAHRiNGON	Southern African human Rights NGO Network
SAMA	South African Medical Association
SAMDC	South African Medical and Dental Council

SAP	South African Police
SAPS	South African Police Services
TRC	Truth and Reconciliation Commission
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCHR	United Nations High Commissioner for Refugees
WMA	World Medical Association

CHAPTER 1

1.1 INTRODUCTION

Historically police brutality in South Africa gave cause for concern, especially in light of the human rights violations committed by police and security forces. These forces violently enforced the pernicious racism embodied by a repressive authoritarian political system (Chapman & Rubenstein 1998; Langa n.d., p. 13).Police brutality under apartheid was "widespread and systematic" (Coleman 1998, p. 53) and included the use of torture and cruel, inhuman and degrading treatment against mainly but not limited to, political activists (Muntingh 2011, p. 7; Langa n.d., p. 9). Of late more and more voices are being raised, warning of increasing levels of police brutality (Pothier 2013). Regrettably the practice of torture and cruel, inhuman and degrading treatment remains a source of major human rights violations in post-apartheid democratic South Africa.

Recently both local and international media has publicised the excessive use of force by police. Examples of these cases include the Marikana mining massacre (Marinovich 2012); the cases of Andries Tatane (Pithouse 2011) and Mido Macia (Newham 2013 ; Burger 2013). Most recent is the case of Biza Mahlangu who was assaulted by police officers on Christmas Day and later succumbed to his injuries in a local clinic (SABC Radio News, 6 January 2014). Social media has also contributed to increased awareness of police brutality (Wyngaardt 2014).

While these incidents have attracted much public interest it is not clear whether these are isolated incidents or only those that receive media attention. Quantitative monitoring of police violence and torture in South Africa in the post-apartheid era is an under-researched area. The bulk of violations perpetrated by the South African Police Services have not been subject to effective monitoring (Pigou 2002, para.1). Based on anecdotal evidence from medical doctors in the Midrand area it would appear that these doctors are being consulted for medical treatment by victims of physical abuse by members of the police services. Although the treating doctors are made aware that the injuries sustained by the patients are allegedly the result of police abuse, it is not clear to them whether they as doctors have a moral and/or legal *duty* to report this abuse. Furthermore to whom should the abuse be reported? The dilemma is even more pertinent when we remember the complicity of most medical professionals and their respective professional bodies with the state, police and security forces, and human rights violations under apartheid (McLean & Jenkins 2003, p. 137).

Currently public knowledge of the abuses of power by the police is the result of either media publicity featuring sensational incidents or the release of the annual report by the Independent Police investigative Directorate. Press reports are not necessarily a meaningful indicator of trends in police brutality, but they do give insight as to the nature of police brutality (Bruce 2002). Further, the statistical indicators of police abuse provided by IPID reflect only those incidents where complaints have been made and investigated (Bruce 2002 ; Langa n.d., p. 8) and are a distortion of the reality.

Some statutes in South Africa impose a duty on medical doctors to report suspected physical and mental abuse in certain categories of patients, for example, in child abuse or abuse of the elderly. The medical practitioner is also guided by the statutes as to the relevant authority to report these incidents. Failure to report in terms of the aforementioned statutes may constitute either a criminal offence or action for criminal negligence (McQuoid-Mason & Dada 2011, p. 175). Together with the reporting and monitoring of infectious or notifiable diseases, this is governed by current professional guidelines.

There seems to be no clear, prescribed law or ethical guideline or action for medical doctors to take when confronted with the physical or mental abuse of suspects, arrestees, those in the country illegally, or those "innocents" that are victimised or bullied by the police.

From the above it is reasoned that since the duty or obligation of the medical practitioner in these cases is unclear and that if, following an examination of current professional guidelines and law, the guidelines are deemed to be deficient in providing doctors with guidance, a standardised code of ethics and guidelines consistent with the integrity of the medical profession, would help doctors to make decisions regarding action to be taken following the treatment of victims of alleged police abuse.

The following review forms part of a textual critique of existing literature and guidelines. It aims to lay a foundation to formulate proposals to guide medical doctors in South Africa when faced with the dilemma between conscience and

possible complicity when treating victims of police abuse or brutality. The review analyses existing national and international professional guidelines and relevant international and national law, to see if duty emerges from the guidelines and law.

Reporting police brutality raises ethical issues: violations of patient confidentiality, informed consent, threats to patient safety (especially where that patient has been identified as vulnerable for whatever reason) and possible difficulty for the medical doctor in maintaining a neutral stance in relation to issues of blame and guilt. Although these issues also need to be debated, they will not be discussed in this report. The benefit of reporting police brutality would be primarily to expose and prevent unreasonable violent behaviour and human rights violations. This would protect detainees and the public; prevent police intimidation; encourage a more accountable and lawful police force and finally, establish a relationship of trust between the public and the medical profession. Reporting police brutality would also provide quantitative data that could be used to inform or advocate for changes in South African policing. This data could be used to effectively monitor human rights violations by the South African Policing Services.

Chapter 1 begins with a definition of police brutality. This is followed with a contextualisation of police brutality in South Africa, the evolution of South African professional medical organisations and the role of the medical doctor.
Chapter 2 examines current national and international ethical guidelines, national and international law, and finally humanitarian and human rights law pertinent to police brutality as it is defined in this research.
Chapter 3 provides a critique and analysis of the guidelines and law.

Chapter 4 concludes with recommendations with regard the medical doctor's duty to report and prevent police brutality.

1.2 METHOD

This study is a normative review of existing available literature based on desk-top and library based research. It begins with a short history of police brutality in South Africa and the evolution of current South African medical professional bodies as they stand today. This is followed by an interrogation of the current ethical guidelines as prescribed by the Health Professionals Council of South Africa and the South African Medical Association. A review of international guidelines such as the World Medical Association and various international human rights declarations and protocols, specifically the Istanbul Protocol is also conducted. Further, some national and international law pertinent to the research is scrutinised. This is followed by an examination of the current police brutality reporting processes as described in the current guidelines provided by the Independent Police Investigative Directorate.

Particular attention is paid to the Istanbul Protocol (a protocol produced by health professionals, lawyers and human rights experts in Turkey, facilitated by Physicians for Human Rights). This protocol addressed ethical dilemmas in the face of legal and moral duties to expose human rights violations (namely torture and cruel, inhuman and degrading treatment or punishment) and provides a manual which prescribes a minimum standard for collecting evidence of and reporting torture and cruel, inhuman and degrading treatment. The methodology contained in the manual is applicable to other contexts including human rights violation investigations and

monitoring. Since police brutality will be established as a human rights violation, the Istanbul Protocol is used in this study as a model for the reporting of police brutality. Special attention is also given to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment which was signed by South Africa on 29 January 1993 and ratified by South Africa on 10 December 1998.

1.3 ANALYSIS

Ethical analysis in this report utilises a rights-based approach. The reason for this approach is that at the core of the Constitution of South Africa (Act 108 of 1996) is the Bill of Rights (Chapter 2), which is based on and incorporates international human rights. South Africa has also ratified many of the international Human Rights Standards. Further, Chapter 9 of the South African Constitution (1996) provides for the existence of six "state institutions" intended to strengthen constitutional democracy (Bruce 2002, section 5 (e)). Of these, the South African Human Rights Commission has played the most prominent role in raising issues of police brutality (Bruce 2002).

Though human rights generally fall to governments, human rights norms have implications for the conduct of medical doctors in that they (among all people) by the nature of their profession have a responsibility to strive for the promotion and observance of human rights (International Dual Loyalty Working Group 2002, p. 13). The profession also imposes obligations on medical doctors to serve, improve and protect society (HPCSA 2008, Booklet 1). Further, the Health Professionals Council of South Africa and the Medical Association of South Africa have explicitly adopted a

language of human rights in their ethical principles. The protection of the human rights of patients is a basic tenet of their principles and of professional duty.

Rights can be considered natural: we have certain rights just because we are human and as such we are entitled to life, liberty and property (Nickel 2014). In contemporary theory, these rights have come to be referred to as universal human rights and form the basis for establishing and evaluating ethical standards within a social order (Nickel 2014). Duties associated with human rights often require actions that involve respect, protection, facilitation and provision (Nickel 2014). The moral appeal of human rights has been used for a variety of purposes, from resisting torture and arbitrary incarceration to better social conditions and access to healthcare (Sen 2004, p. 315). What is central to human rights is that every person has some basic rights that others have a duty to respect (Sen 2004, p. 321). Human rights principles are thus considered moral or ethical demands rather than legislative commands (Sen 2004, p. 319).

Sen (2004, p. 321) argues that a theory of human rights should address four questions:

1. What kind of statement the declaration of human rights makes
2. What makes human rights important
3. What duties and obligations are generated by human rights
4. Through what forms of actions can human rights be promoted and whether legislation must be the principal or even necessary, means of implementation of human rights.

These four points are used to guide the critique and analysis.

Rights-based ethical reasoning involves 'determining whether an action is right or wrong according to whose and which rights are upheld or violated by the act in question' (Nickel 2014). An example of such a right would be the right to be free from torture or cruel, inhuman or degrading treatment. Thus the general principles are that either an action is wrong because it violates a right or that one should respect the right of others to a prescribed freedom. In other words one has to decide what rights are involved and their basis. The rights-based approach in this research will integrate the norms, standards, principles and goals of the international human rights system as well as those entrenched in the Bill of Rights (Chapter 2, The Constitution of South Africa, Act 108 of 1996) and the national medical professional guidelines.

CHAPTER 2

2.1 CONTEXTUALISING POLICE BRUTALITY, THE ROLE OF THE MEDICAL DOCTOR AND THE EVOLUTION OF SOUTH AFRICAN MEDICAL PROFESSIONAL ORGANISATIONS

2.1.1. Defining police brutality

The generally accepted definition of police brutality is 'the unlawful, deliberate excessive use of force' in carrying out policing duties (Bruce 2002, section 2). This definition is inadequate in that it does not describe either the purpose or the type or degree of the use of force. For example, police using batons for the purpose of crowd control during a protest march might be considered lawful, reasonable and rational and certainly not excessive. But police using batons to beat a handcuffed arrestee into submission would not be considered reasonable but rather excessive, unlawful and deliberate. If those same actions were used to extract a confession from an arrestee in detention, it would be deemed torture.

The problem with defining police brutality is that it is not restricted to either a problem of torture or to those in custody (Bruce 2002). Police brutality includes acts of other serious nature and may include deaths consequent to torture or acts outside of custody and even on persons reporting cases to the police (Bruce 2002). It is for this reason that the term needs clarification. Further, for the purpose of this paper there is a need to differentiate between torture and cruel, inhuman or degrading treatment (CIDT). The reason for this is that this paper is focusing on police brutality *on the*

street, in a public space or in a holding cell, rather than police brutality on those sentenced and imprisoned. Also, whereas torture may be considered as absolutely prohibited, CIDT by definition is a relative concept (Nowak & McArthur 2006) and is not absolutely prohibited. Nowak and McArthur (2006) argue that the criteria for distinguishing torture from CIDT is not (as in all other international definitions) the intensity of pain or suffering inflicted, but the purpose of the conduct and the powerlessness of the victim. The distinction is therefore primarily the question of personal liberty (Nowak and McArthur 2006).Thus outside a situation of detention or similar direct control the excessive use of police force constitutes CIDT. Conversely in a situation of detention or similar direct control, any use of mental or physical force against a detainee with the purpose of humiliation constitutes degrading treatment or punishment. Any infliction of severe pain or suffering for the purpose of extracting a confession, obtaining information, punishment, intimidation or discrimination is torture. Therefore if the purpose of the use of force is disproportionate in relation to the purpose to be achieved and results in severe pain and suffering (physical or psychological), it amounts to cruel or inhuman treatment or punishment. If such force is used in a particularly humiliating manner, it may be qualified as degrading treatment even if less severe pain or suffering is thereby inflicted (Nowak & McArthur 2006). If however, the police use non-excessive force for a lawful purpose, then the deliberate infliction of severe pain or suffering simply does not reach the threshold of CIDT. An example would be where a suspect attempts a murder and resists police attempts to stop them, leading to that suspect being shot at by the police. In this case the force used would be deemed appropriate. It should thus be recognised that there are legal prescriptions and codes for the use of force by the police, but where these prescriptions are exceeded disproportionately to the purpose, it is CIDT.

Holding this clarification and explanation I contend that police brutality, at the very least, is equal to CIDT and is hereafter considered synonymous. For the purposes of this study I have also drawn on the definition of torture and CIDT provided by the Inter-American Convention to Prevent and Punish Torture (1987). This definition specifically mentions 'for the purposes of criminal investigation' which implicates the police forces and excludes the military and other security forces that may also use torture or CIDT methods.

The Inter-American Convention to Prevent and Punish Torture (Article 2) defines torture and CIDT as:

> ...any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for *purpose of criminal investigation*, as a means of intimidation, as a personal punishment, as a preventative measure, as a penalty or for any other purpose. Torture [and CIDT] shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.

2.1.2 The History of Police Brutality in South Africa

South Africa has a long history of police brutality, torture and CIDT. Before the current democratic regime, much police brutality in South Africa was politically motivated by apartheid and most victims of torture and CIDT were either political activists or political opponents (Muntingh 2011, p. 11; Langa n.d., p. 8). Police brutality was largely unreported during the apartheid era because South Africa was subject to widespread censorship and counter-propaganda initiatives around the issue of repression and human rights violations (Pigou 2002, para 2). The

consequences of police brutality were also not reported by treating physicians for two possible reasons; either there was no standardised ethical process or professional guidelines or, because doctors treating the consequences of brutality were complicit with the state, consistent with an apartheid-type social conditioning (Cawthra 1992, p. 6; Jenkins & McLean 2004, p. 36; Silove 1990, p. 417).

South African physicians under apartheid were widely expected to put the security and other interests of the state ahead of their ethical commitments to patient well-being (Chapman & Rubenstein 1998).Similarly the institutions that were responsible for health policy lacked independence resulting in acts of omission and commission by statutory bodies such as the South African Medical and Dental Council (SAMDC), contributing to violations of human rights (Chapman & Rubenstein 1998).

Under that political regime, the Black Consciousness leader, Steve Biko, infamously died in detention in 1977 (Baxter 1985, p. 139; Jenkins & McLean 2004 ; Woods 1991). Biko's death was consequent to both police torture and CIDT, and medical complicity and neglect (Baxter 1985, p. 139; McLean & Jenkins 2003). His death specifically raised a number of medical ethical issues as well as critical moral obligations of both medical doctors and their respective professional bodies (McLean & Jenkins 2003) and his case has become seminal internationally in studies and debates to do with medical ethics and dual loyalty (McLean & Jenkins 2003).

The courage and advocacy of doctors Wendy Orr, Frances Ames and many others (International Dual Loyalty Working Group 2002, p. 48; SAMJ 2003, p. 14) drew attention to the atrocities committed by the police and prison systems under

apartheid notably, those actions against (but not limited to) political detainees (Pigou 2002, para. 2). Their reporting and documenting of brutality against prisoners and detainees helped improve conditions for future detainees and simultaneously raised awareness of the abhorrence of police brutality, medical complicity and human rights violations. The actions of these doctors also highlighted ethical problems surrounding police services and medical "alliances", primarily that of divided or dual loyalty, and consequent human rights violations.

2.1.3 The Evolution of Health Professional Bodies and the Role of Doctors

In 1994, following the demise of apartheid and in the advent of democracy, the Truth and Reconciliation Commission (TRC) was set up with the objective of promoting reconciliation amongst South Africans and fostering respect for human rights in the interests of nation-building (Baldwin-Ragaven,de Gruchy & London 1999, p. 4).

The health sector was the first specific sector of civil society to have its own set of hearings (Chapman & Rubenstein 1998) . The TRC examined those specific abuses the took place under the guise of health care practioner's professionalism (Baldwin-Ragaven,de Gruchy & London 1999). The TRC investigation revealed not only the medical community's record of pervasive and institutionalised racism but also its gross violations of human rights, and its "wilful abandonment of ethical commitments of medicine" (Chapman & Rubenstein 1998, p. 183). As a result of their investigation the TRC recommended (amongst others) that the health sector should adopt human rights standards for all health professionals; improve the regulation of professionals

and professional organizations as well as to increase the monitoring and reporting on health and human rights (Bell 2006, p. 71).

In accordance with the new democratic constitution, the two main medical professional bodies, namely the South African Medical and Dental Council (SAMDC) and the Medical Association of South Africa (MASA) were re-established as the Healthcare Professions Council of South Africa (HPCSA) and the South African Medical Association (SAMA). Both seek to serve to guide the medical professional both professionally and ethically in protecting the public and upholding human rights (McQuoid-Mason & Dada 2011, p. 208; p. 390). SAMA also established a Human Rights Law and Ethics Committee to deal with issues relating to human rights.(SAMA 2012).

South Africa's apartheid history made the drafters of the Constitution aware of the issue of torture and the importance of the right to be free from torture (Muntingh 2011, p. 11). Thus the right to be free from torture was written into the Constitution of South Africa (Act 8 of 1996), in section 12 (1)(e) under the heading of 'Freedom and security of person' (Muntingh 2011, p. 11).

The Constitution requires that there should be respect for the dignity of a person and this implies that central to the right to dignity is the right not to be tortured or treated in a cruel, inhuman or degrading way. The right to dignity serves not only to protect individuals against actions adversely affecting them but also places a positive obligation on the State to act proactively to prevent all peoples' dignity from being negatively affected (Muntingh 2011, p. 12).

Due to the increasing levels of crime in South Africa, there is public sentiment that police are not authoritative enough or that the judicial system is failing (Langa n.d.,p. 27). The result may be that police are resorting to violent means of dealing with alleged criminals (Dissel, Jensen & Roberts (2009) as cited in Langa n.d., p. 27). Recent rhetoric by politicians and senior police officers, such as "shoot to kill" (Newham 2013, para. 7) also seem to have created a "discourse in which violence or torture against alleged criminals is implicitly (if not explicitly) condoned" (Langa n.d., p. 27).

Though the Constitution guarantees the right to freedom from torture and CIDT, these two issues remain a problem in contemporary South Africa. The present difference is that victims are no longer primarily political activists, but belong to marginalised groups, such as criminal suspects and prisoners (Langa n.d., p. 8) and illegal immigrants. Muntingh (2011, p. 11) argues that because many victims of torture and CIDT are criminal suspects, "this does not evoke the same moral condemnation as when victims were political activists under apartheid" .

It is also established that victims of police abuse are not always alleged or suspected criminals. According to annual reports (2009 and 2011) IPID have also investigated cases where police have used deadly force against innocent civilians who imposed no threat to law enforcement officials nor resisted arrest (Langa n.d, p. 30). The police not only use excessive force to restrain violent criminals or when under threat but are also using excessive force when entirely unprovoked. The assault and torture of service delivery protestors is also cause for concern (Langa n. d., p. 31; and as examples, Andries Tatane; the Marikana miners).

The excessive use of force and violence by the police violates the rights of criminals under Section 35 of the Constitution of South Africa (Act 108 of 1996) and the rights of all citizens under Section 12 (1)(e). In an effort to overcome the legacy of torture by police officials under apartheid, the democratic South African government established the ICD (now IPID) to monitor police force violations of duty (Pigou 2002, para. 20). Victims may complain to IPID which is obligated to investigate the complaints. Many cases of assault are not reported to IPID due to general public ignorance about the IPID ; limited access to IPID (Pigou 2002, para. 21); victims being economically challenged or IPID being viewed as a "toothless" state institution in dealing with their complaints (Langa n.d., p. 31). Victims may also not report for fear of reprisal, or in some cases the victims may be illegal immigrants and risk deportation. With the exception of death in custody or as a result of police action (which IPID is obligated to investigate), the IPID's perception of police brutality is governed by the complaints referred to them (Pigou 2002, para. 21; IPID 2012, p. 4). Thus existing police brutality statistics in South Africa need to be treated with caution as it is possible that the figures may be inaccurately underestimating the extent of the problem.

Medical doctors can play a role in terms of exposing or covering up human rights violations in documenting, recording and advocating against many forms of these violations. In almost all incidents of police brutality, depending on the severity of the injuries, victims of police brutality seek medical attention. This treatment may be sought in the public or the private sector. Treatment requires more than physical caring for injuries, and includes an examination and history taking.

One of the functions of the medical practitioner, other than treating and healing, is to protect and promote the human rights of both their subjects and society (Audet 1995, p. 609). This is one of the basic tenets pervasive throughout national and international professional codes as well as national and international law and it is with this in mind that I argue that medical doctors should, in order to protect and promote human rights, report police brutality. This reporting would facilitate effective quantitative monitoring of incidents of police brutality and would enact a change in policing methods and accountability.

CHAPTER 3

3.1 REVIEW OF GUIDELINES AND LAW

3.1.1. Introduction

Police brutality is a human rights violation equal to torture or cruel, inhuman or degrading treatment or punishment and is not merely an assault, an assault to do grievous body harm, attempted murder or even murder consequent to police violence. Further, police brutality, as has already been established, is more than the generally accepted definition of police brutality as a "deliberate, unlawful action" or "the (unlawful) abuse of the capacity to use force" (Bruce 2002, pp. 4-5). Actions that amount to criminally negligent uses of force should also be considered as acts of police brutality (Bruce 2002, p. 4).

In a report commissioned by the Southern African Human Rights NGO Network (SAHRiNGON (sic)), intended to document information in 11 SADC (Southern African Development Conference) countries on the factors contributing to police brutality, the form of and the extent of police brutality, and on institutional responses to the problem, David Bruce (2002) argued that in light of the history of brutality by the South African Police (SAP) under the system of apartheid, there would be considerable justification for the exploration of questions to do with police brutality in contemporary South Africa under the South African Police Service (SAPS). The nature of policing, according to Bruce (2002), is intimately involved with the use of force which will inevitably proliferate unless concerted steps are taken to discourage

it. Physical abuse has been a traditional method of policing in terms of functions of protection, enforcement and investigation (Pigou 2002, para. 45). There is a widespread reliance for police to use or tolerate such practices. South African policing can be said to reflect a "habit of brutality" (Bruce 2002, p. 27). Transformation of the police requires that police be taught how to carry out their role without relying on brutality (Bruce 2002).

While police brutality under apartheid was largely politically driven, crime and policing are always political (Bruce 2002). This is even more evident in a country like South Africa where the threat of violent crime is a constant for many South Africans (Faull & Rose 2012, p. 1) and the State has to be seen to be controlling the crime. The media has proposed that under the current political leadership reports of police brutality have more than tripled in the last decade in an effort to control crime (The Guardian, 23 August 2013). Under Jacob Zuma's government there has been a "deliberate policy" (Faull & Rose 2012, pp. 9-12) that involves encouraging greater use of force by the SAPS. Faull and Rose (2012, p. 11) argue that the consequence of political rhetoric (regarding policing, crime and policy), statements such as the idea that the solution to containing crime is to escalate violence by police against criminals or that statements such as "shoot to kill" (Langa n.d., p. 27; Burger 2013) is:

> " a general celebration of violence and force as a solution to crime, manifesting in increased abuse and death at the hands of the police, but also in regular incidents of vigilante justice. The irony that violence is held up as a solution to violence appears lost on many political and police leaders"

The Council for the Advancement of the South African Constitution (CASAC) submitted to the Marikana Commission of Inquiry that the "deliberate policy" (Faull and Rose 2012; de Vos 2013) encouraging the greater use of force by members of the SAPS seems to have been advanced through the promotion of semi-formal and illegal doctrine of "maximum force" (de Vos 2013). This submission was substantiated by pointing to a statement made by the then Deputy Minister of Safety and Security, Susan Shabangu on 9 April 2008 to the effect that the SAPS should:

> ...kill the bastards (criminals) if they threaten you or the community. You must not worry about regulations. I want no warning shots. You have one shot and it must be a kill shot. I want to assure the police station commissioners and policemen and women... that they have permission to kill these criminals.. (de Vos 2013).

Justification for an investigation into police brutality is strengthened by local and international media publicity that highlights incidents of police brutality and the use of excessive force . An example is the case of the Mozambican taxi driver Mido Macia being dragged behind a police vehicle and allegedly being beaten by the same arresting police officers before finally succumbing to his injuries in a police cell (de Vos 2013; Burger 2013): a scenario redolent of the aforementioned death of Steve Biko. It would appear that at no time was he afforded any medical treatment and that Macia's death was consequent to a number of human rights violations (Burger 2013; de Vos 2013). A more recent example is that of Biza 'Boy' Mahlangu (25 December, 2013), originally arrested for drunk driving, then allegedly fatally beaten by the police (including two female officers). The case is currently under investigation (SABC Radio News, 6 January 2014).

According to the 2012 Country Report of Human Rights Practices in South Africa (United States Department of State 2013), South Africa is in violation of a number of human rights, namely respect for the integrity of the person, which includes the unlawful deprivation of life; torture and other cruel, inhuman or degrading treatment or punishment of persons; the abuse of refugees and asylum seekers as well as arbitary arrest or detention (United States Department of State 2013). As far back as 2000, Mary Rayner, an Amnesty International researcher reported that while the there were at least 20-30 severe cases of torture by the police reported in South Africa, that there were most likely many more incidents not reported [and by implication that members of SAPS were thus able to act with impunity] (Bruce 2002, para. 2). In its 2012 annual report Amnesty International documented allegations against the South African police and expressed concerns about police excessive force, torture, rape and "extrajudicial executions" (de Vos 2013; Langa n.d, p. 29; Amnesty International 2013). It has also expressed concern about brutal training methods for police (Bruce 2002 ; Amnesty International 2013).

The Independent Police Investigative Directorate (IPID) Report for the period 2012-13 (which reported 4131 complaints of assault[1] by the police brought forward for investigation[2]) provides further evidence for the need for investigation into police brutality, accountability for brutality and the monitoring of human rights violations. From this report, it would appear that there may be a discrepancy between the number of charges laid and the number of convictions secured . This discrepancy may be influenced by a number of factors, such as: abusive practices by the police

[1] At the time there was no law criminalising torture and CIDT and thus cases were investigated as a lesser charge of assault

[2] This does not include deaths in police custody, death as a result of police action, rape or torture by the police

are under-reported by the public; investigations are under-resourced and inadequately prioritised; incidents of abuse often take place where supporting evidence cannot be secured; court cases against police officials do not receive priority attention (Pigou 2002, para. 21).

It is also often difficult to ascertain whether the allegations of police brutality should be treated as credible or not. There are often no witnesses to the abuse except other police officers. Further, there is no standardised process or protocol to ascertain the credibility of these claims. However, if excessive force or CIDT has occurred the resulting injuries would surely be severe enough to require medical consultation and treatment.

It is widely recognised that doctors are often the first in any society to see evidence of torture and police brutality (Lucas & Pross 1995, p. 109), either through the provision of prison medical care, through the treatment of victims in police stations or through the conduct of post-mortem examinations (International Dual Loyalty Working Group 2002 ; Lucas & Pross 1995, p. 108). It is unknown whether these reports include incidents where medical treatment was be sought in either the public or private sector although as previously mentioned it is known that some victims have sought treatment privately.

Human rights violations by police force members,which result in physical and even psychological injury for victims, have moral implications for those health care professionals who treat the results of that abuse. When treating the survivors of the abuse directly; by identifying CIDT related injury through the performance of post-

mortem examinations; or by carrying out other professional tasks, doctors are placed in a postion where they can play a key role in terms of exposing or concealing human rights violations (Lucas & Pross 1995, p. 106).

Current procedure for the reporting of police abuse in South Africa is that either the victim of abuse, or a witness to police abuse must make a complaint to the Independent Police Investigative Directorate. The complaint then facilitates an investigation which may lead to either possible prosecution and/or financial compensation. This raises the issue of the duty or obligation for a treating medical doctor to report evidence of police abuse or brutality. Most commonly, while aware of the abuse, medical doctors may believe they are powerless to affect the abuses. However, unless cases are reported to the IPID no investigation will take place. Many victims may be resistant to reporting police abuse, for reasons previously mentioned. Thus, the abuse will go undocumented in current reports and statistics, and police brutality will continue with impunity. IPID provides that anyone (including witnesses) with a complaint of police brutality can report this abuse but it should be considered whether the doctor (as a witness to the injury) has a duty to report police brutality. Further,the implications of reporting for the doctor in question as well as for the victim of the abuse should be considered.

3.2 CURRENT MEDICAL ETHICAL GUIDELINES

Codes of medical ethics are moral principles that govern the practice of the medical profession. The codes or standards are produced by international and national regulating bodies and set standards for the medical professions. These codes do not

normally bear the weight of the law unless they have been incorporated into statutes or regulations.

3.2.1 South African Medical Professional Guidelines

Medical doctors have a unique social responsibility as healers as well as to understand and alleviate the causes of human suffering and to promote health (Chapman & Rubenstein 1998).There are very clear links between concepts of human rights and the principles of health-care ethics (United Nations 2004). When conceptualisations of health and human suffering are deficient of human rights concerns, medical practitioners can become willing or unwilling participants in human rights abuses which serve the interests of the state and other actors (Chapman & Rubenstein 1998).

In South Africa the ethical obligations of health professionals are prescribed at three levels namely: i) at a national level (as provided by the national and statuatory bodies); ii) internationally as prescribed by international professional bodies and iii) as articulated by United Nations statements relevant to health professionals.

3.2.1.1 The Health Professions Council of South Africa (HPCSA)

The Health Professions Council of South Africa (previously known as the South African Medical and Dental Council) is purported to be the guardian of public interests insofar as the public are affected by members of the profession (McQuoid-Mason & Dada 2011, p. 208). The HPCSA is a juristic body established by the

Health Professions Act, 1974 (Act 56 of 1974)(s2) and has its head office in Pretoria (McQuoid-Mason & Dada 2011, p. 208).

Some of the HPCSA objectives are to promote and regulate inter-professional liason between registered professions in the interests of the public and determine strategic policy with regard to matters of ethics and professional conduct (amongst others) (McQuoid-Mason & Dada 2011, p. 208).

The Council must report to the Minister of Health any information of public importance acquired by the Council in the course of the performance of its functions in terms of the Act; to serve and protect the public in matters involving the rendering of health services by persons practising in a health profession and to uphold and maintain professional and ethical standards within the health professions (McQuoid-Mason & Dada 2011, p. 208).

The HPCSA acknowleges healthcare as a moral enterprise and has established guidelines to guide medical professionals when facing ethical dilemmas. The HPCSA publishes national guidelines for healthcare professionals in South Africa and has produced 12 booklets on ethical guidelines for doctors. These guidelines were last updated in 2008 and comprise 12 booklets.

In terms of the Health Professions Act 1974 (Act 56 of 1974, s 17 (1)(a)) registration with the HPCSA is compulsory for medical doctors wishing to practice in South Africa and this registration confers on that professional the right and privilege to practice the said profession. Similiarly, this right to practice confers moral and ethical duties

to others and to society (HPCSA 2008, Booklet 1). The HPCSA guidelines argue that the ethical guidelines express duties, and that a duty is an obligation to do or to refrain from doing something (HPCSA 2008, Booklet 1, Section 4).

The prescribed duties of the medical doctor are in keeping with the Constitution of South Africa (Act 108 of 1996) and legal obligations imposed on the medical doctor. The guidelines however state that no duty is absolute (HPCSA 2008, Booklet 1, Section 4.8) and provides an example of dual loyalty to illustrate the point.

The introduction to Booklet 1, section 2 (HPCSA 2008, p. 2) describes core ethical values and standards for good practice required by the medical doctor as amongst others, *respect for patients as persons; acknowledgement of the patient's intrinsic worth, dignity and sense of value; and finally, acting in the patient's best interests, specifically that the medical doctor should not harm or act against the best interests of the patient, even where the interests of the patient are in conflict with their own self-interest.* Medical doctors should also *recognise the human rights of all individuals and honour the right to autonomy and confidentiality. Medical doctors should strive to contribute to the betterment of society in accordance with their professional ability and standing in the community (*HPCSA 2008, Booklet 1, p. 3).

Since doctors fulfill different roles, they accordingly have different duties, that is natural duties, moral obligations and finally institutional duties. Further, these professional duties may be ethical, legal or both at once. Of these duties, the natural duties are of particular interest in that they refer to "general unacquired duties simply as members of the human community". These natural duties are duties *to refrain*

from harm, to promote the good and to be fair and just. These duties are owed to all other people whether patients or not and quite independently of professional qualifications (HPCSA 2008, Booklet 1, p. 4).

Most significant to this research is that the guidelines prescribe *that medical doctors should recognise the human rights of all individuals,* patient autonomy and respect their patients' right to confidentiality unless overriding reasons confer a moral or legal right to disclosure.

Section 5 of Booklet 1 (HPCSA 2008) prescribes the medical doctor's duties to patients. Point 5.1.5 (HPCSA 2008, Booklet 1) recommends that healthcare professionals should " *Make sure that their personal beliefs do not prejudice their patients' healthcare. Beliefs that might prejudice care relate to patients' race, culture, ethnicity, social status,lifestyle, perceived economic worth...any condition of vulnerability".*

Healthcare professionals should also *"guard against human rights violations of patients, and not allow, participate in or* ***condone*** *any actions that lead to violations of the rights of patients"* (HPCSA 2008, Booklet 1, point 5.2.5).

Healthcare professionals should also not disclose personal or confidential information acquired in the course of their duties unless the patient consents to the disclosure, or unless the healthcare practitioner has a good and overriding reason for doing so, that is, where a non-disclosure leads to the likelihood of serious harm to an identifiable third party or any overriding and ethically justified legal requirement

(HPCSA 2008, Booklet 1, section 5.4). The healthcare professional is also guided not to breach confidentiality without sound reason and without the knowledge of the patient (HPCSA 2008, Booklet 1, section 5.4).

Interestingly in section 10,(HPCSA 2008, Booklet 1, p. 10), doctors are *encouraged to report violations and seek redress in circumstances where they have good or persuasive reason to believe that the rights of patients are being violated* and/or where the conduct of another practitioner is unethical (point 10.1.1).

3.2.1.2 The South African Medical Association (SAMA)

The South African Medical Association (SAMA) is a non-statutory professional body that acts as a trade union for doctors in the private and public sector (McQuoid-Mason & Dada 2011, p. 389). It is a section 21, non-profit organisation and is registered under the Companies Act,1973 (Act 61 of 1973).

SAMA is a voluntary association (SAMA 2012). Not all South African medical practitioners are members or subscribers. SAMA affirms the constitutional rights entrenced in the Bill of Rights (Chapter 2 of the South African Constitution (Act 108 of 1996)) and acknowledges that both doctors and patients have rights and responsibilities that are exercised in very real life situations. SAMA believes in 'positively' influencing medical practice by *inter alia* anticipating and influencing health policy changes.

SAMA recognises that both doctors and patients have the right to freedom and security of the person that is, to be *free from cruel, inhuman or degrading treatment; and to be free from violence* (SAMA 2012).

SAMA importantly also cites that every doctor has the :

> responsibility to ensure that patients are not subjected to cruel, inhuman or degrading punishment or treatment and to report instances where such occur, especially within the spheres of prison, detention etc, as well as the abuse of children and the elderly.

Every doctor has the responsibility to assist in the realisation of the right of access to healthcare of all arrested, detained and accused persons and to bring to the attention of the authorities or inspecting judge any irregularites or needs in relation to healthcare.

Every patient in detention has the right to medical care and to raise concerns in relation to health issues, either to the relevant healthcare workers or to the authorities, and to have such concerns addressed expeditiously. Doctors also have the right not to be forced to take part in any unlawful (bodily) search or seizure and have *the right to enquire as to the status of the subject brought to them , as well as the legislation in terms of which this was done.* Both doctors and patients have the rights to fair treatment when arrested, detained or accused, in accordance with section 35 of the Constitution of South Africa (Act 108 of 1996). SAMA concedes that all rights may be limited by a law of general application and that this law has to be reasonable and justifiable in a democratic society and conform to the requirements set by section 36 of the Constitution of South Africa (Act 108 of 1996). The Association also declares that it will not participate in the unlawful limitation of the

rights of any person or organisation and will seek to uphold the values entrenched in the South African Constitution (Act 108 of 1996).

Following TRC recommendations, SAMA established a Human Rights, Ethics and Law committee to drive a process to implement and promote a human rights culture in the health sector (van der Merwe 2000). In order to achieve this, the Committee identifies priority areas upon which they focus their efforts during their term. It also provides an advisory role to members on matters concerning human rights, law and ethical matters (SAMA 2012).

Other than guidelines on mandatory reporting of abuses such as that of child or elder abuse, or how to approach cases of assault (not by police services), SAMA does not elaborate on any specific action to be taken when human rights are violated other than a "broad" to report the violations.

3.2.2 International Professional Guidelines

Many statements from international professional bodies focus on principles relevant to the protection of human rights and represent a clear international medical consensus on issues of torture and thus for this paper, police brutality (United Nations 2004). Declarations of the World Medical Association (WMA) define internationally agreed aspects of the ethical duties to which all doctors are held.

3.2.2.1 World Medical Association Declaration of Geneva of 1948 (as amended)

In most countries a modernised version of the Hippocratic Oath is used because the language of the original oath is considered archaic (McQuoid-Mason & Dada 2011, p. 212). The Declaration of Geneva of 1948 (as amended) is an example of a modern "Hippocratic Oath". The Declaration prescribes that the medical doctor will pledge himself to the service of humanity and will practise the profession with conscience and dignity. S/he also pledges that the health of the patient will be the first consideration and will not be impeded by considerations of religion, nationality, party politics or social standing. The doctor will maintain the utmost respect for human life even under threat and will not use medical knowledge contrary to the laws of humanity.International and national ethical principles have adopted this oath as a central tenet.

3.2.2.2 World Medical Association: Declaration of Geneva: International Code of Medical Ethics (2006)

The above code provides that 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 also has a duty to always bear in mind the obligation to respect human life; to act in the patients best interests when providing medical care; respect a patients right to confidentiality unless the patient has consented to such disclosure or when there is a real or imminent threat of harm to the patient or to others and this threat can only be removed by a breach of

confidentiality.Finally, a physician shall owe his/her patient complete loyalty (World Medical Association 2006).

3.2.2.3 Declaration of Tokyo (1975) (Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention or Imprisonment)

The Declaration of Tokyo on Guidelines for Physicians concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment (1975) provides the ethical framework for the treatment of detainees or prisoners. The Declaration begins with the statement that " a doctor must have complete clinical indepence in deciding upon the care of a person for whom he or she is responsible". Further, the Declaration provides that it is the duty of the physician to heal, alleviate suffering, provide comfort and act in the best interests of his or her patients. Doctors should also not countenance, *condone* or participate in mental or physical torture or other forms of cruel, inhuman or degrading procedures- whatever the offence of which the victim is suspected, accused or guilty, and whatever the victim's motives or beliefs. This includes all situations whether they be the result of armed conflict or civil strife. The basic premise in the declaration is

> " the physician's fundamental role is to alleviate the distress of his or her fellow human beings... and no motive, whether personal, collective or political, shall prevail against this higher purpose".

Thus, no degree of political convenience must be allowed to tamper with this definition and every effort should be made, especially by doctors, to reject any attempt to justify torture (Justo 2006, p. 1463).

It is also prescribed that medical doctors should respect patient confidentiality; try to prevent the use of medical records for interrogation purposes and respect the wishes of mentally and legally competent detainees. Doctors should also avoid situations of dual loyalty that may compromise their first duty towards their patients.

The Declaration importantly prescribes that physicians have an *obligation to diagnose and treat victims of torture* and are prohibited from conducting any evaluation that may facilitate the future or further conduct of torture. It does not elaborate on how to act or what to do when confronted with torture or CIDT or how to prevent torture or monitor trends in torture. It is presumed that these are merely guidelines that leave further action up to the State or state professional bodies.

3.2.2.4 World Medical Association Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003, amended October, 2007)

This resolution was written in consideration of the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading

Treatment or Punishment, adopted by the United Nations General Assembly (1982) which states:

> ***" It is a gross contravention of medical ethics...for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment..."*** .

The IP was also written in consideration of the Convention Against Torture (1984) as well as the Istanbul Protocol, amongst other conventions. The resolution recognises that careful and consistent documentation and denunciation by physicians of cases of torture and of those responsible contributes to the protection of the physical and mental integrity of victims and in a general way to the struggle against a major affront to human dignity. It also recognises that physicians, by ascertaining the sequelae and treating the victims of torture, either early or late after the event, are privileged witnesses of this violation of human rights and that as a consequence of either intrinsic, extrinsic or both influences that victims are unable to formulate complaints against those responsible themselves, that physicians are in a position to act for them. Further, the resolution recognises that

> ***"the absence of documenting and denouncing acts of torture may be considered as a form of tolerance thereof and of non-assistance to the victims"*** (WMA 2007, page 3 of 4).

The resolution also recognises that there is **NO** consistent and explicit reference in the professional codes of ethics and legislative texts of the obligation upon

physicians to document, report or denounce acts of torture or inhuman or degrading treatment of which they are aware.

In response to these recognitions the WMA resolution recommends that national medical associations attempt to ensure that victims of torture or CIDT have access to independent healthcare and that physicians include the assessment and documentation of symptoms of torture or ill-treatment in the medical records. It is also recommended that national medical associations should promote awareness of the Istanbul Protocol and its Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment and that the Istanbul Protocol should be disseminated to physicians. National medical associations should also attempt to train physicians in the recognition of the physical findings of torture and the correlation between the findings and the victim's allegations of abuse. The associations should also ensure that the physicians understand the principles of informed consent and implement procedural safe-guards that protect the victim. Importantly, this resolution recommends that the national medical associations should support the adoption in their country of ethical rules and legislative provisions:

1. aimed at affirming the ethical obligation on physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of which they are aware; depending on the circumstances, the report or denunciation would be reported to medical, legal, national or international authorities, to non-governmental organisations or to the International Criminal Court bearing in mind paragraph 68 of the Istanbul Protocol

2. establishing, to that effect, an ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible, with the victim's consent, but in certain circumstances where the victim is unable to freely consent, without explicit consent and to ensure that victims' are not endangered by their identification when reporting.

3.2.2.5 The Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment)

The Istanbul Protocol (IP) was devised in response to the needs of Turkish health professionals to expose the routine use of torture in Turkey and covers evidence-gathering and some issues of treatment (English, Romro-Critchley & Somerville 2000, p. 287).The manual outlines the minimum standards to ensure the effective investigation and documentation of torture and ill-treatment in its principles. No international guidelines for the documentation of torture were available prior to the development of this manual. The guidelines are not presented as a fixed protocol but rather as a representation of the minimum standards based on principles and should be used taking into account available resources.

The conceptualisation and preparation of this manual was a collaborative effort between forensic scientists, physicians, psychologists, and human-rights monitors and lawyers working in Chile, Costa Rica, Israel, South Africa, Turkey and others (United Nations 2004, p. 2).

The manual is intended to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body (United Nations 2004). It includes principles for the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment and is recognised by a number of human rights bodies such as the United Nations General Assembly, UN Commission on Human Rights, UN Committee against Torture, United Nations Special Rapporteur on Torture, and African Commission on Human and People's Rights.

This protocol does not specifically prescribe the duties and obligations of the medical doctor to report when confronted with victims of torture or police brutality but rather, provides guidelines on the examination, physically and psychologically, and documentation of injuries that are incurred as a result of excessive force and/or torture as a means to further investigation and victim protection.

The legal section of the Istanbul Protocol provides for prompt, effective and independent investigations; empowerment of the investigative authority; safety of victims and witnesses and impartial investigations amongst others (Moreno and Iacopino 2012).

Importantly the medical aspects of the Istanbul Principles provide that medical evaluations must conform to the Istanbul Protocol standards; be under the control of medical and not security personnel; that evaluations must be conducted promptly and written reports must be accurate and include a detailed account of the abuse

allegations including the methods used and the subsequent physical and psychological symptoms (Moreno and Iacopino 2012). Important in the documentation is the history of the abuse or torture and the correlation of this history with the physical injuries. Psychological history is also important because changes in psychological health consequent to torture and/or CIDT have grave implications for health, well-being and social functioning.

The documentation methods contained in the manual are applicable to contexts other than torture, including human rights investigations and monitoring, political asylum evaluations, the defence of individuals who "confess" to crimes during torture and also for needs assessments for the care of torture victims among others. In the case of health professionals who are coerced into neglect, misrepresentation or falsification of evidence of torture, the manual forms an international point of reference for health professionals and adjudicators alike (United Nations 2004, p. 1).

With reference to issues of patient confidentality, paragraph 68 of the IP cautions that where reporting is a legal and ethical requirement or principle, that medical practioners should take care where victim's refuse to consent to an examination or having their case reported. In these situations the IP argues that the health practitioner has dual responsibilities: to the victim and to society at large (a duty to ensure that justice is done and that perpetrators are held accountable) and these circumstances solutions that promote justice without breaking the victim's right to confidentiality should be sought.

3.2.3 United Nations Statements Relevant To Health Professionals

3.2.3.1 United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (resolution 37/194,1982)

This body of principles was prepared in recognition that not infrequently members of the medical profession are engaged in activities which are difficult to reconcile with medical ethics and in affirmation of the Declaration of Tokyo that any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity, a denial of the Charter of the United Nations and a violation of the Declaration of Human Rights.

Principle 2 states "that it is a *gross contravention of medical ethics*, as well as an *offence under applicable international instruments, for* health personnel, particularly *physicians, to engage, actively or passively, in acts which consitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.*

Principle 4 states that "for the purpose of the Declaration, that torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person, for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has

committed or is suspected of having committed, or intimidating him or other persons". It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners . Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment." Further, under Principle 4, Article 7 of the Declaration states:

> Each state shall ensure that all acts of torture ... are offences under its criminal law. The same shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture.

In accordance with article 7 of the Declaration , each state shall ensure that the commission of all acts of torture as defined in Article 1 of the Declaration, or participation in,complicity in, incitement to act and attempt to commit torture are all offences under its criminal law.

3.3 HUMAN RIGHTS

Human rights impose both active and passive duties and obligations on persons . These duties may be moral, legal or both. The ethical demand for human rights may lead to legislation however a human right does not have to be legislated to be a right. Human rights exist in morality and in law at the national and international levels, and impose duties and obligations on governments and citizens.

Human rights are also defined as universal moral rights that belong equally to all people simply because they are human beings (McQuoid-Mason & Dada 2011, p.

227). They are norms that help to protect all people everywhere from severe political, legal and social abuses (Nickel, 2014).

Universally accepted human rights are codified in the International Bill of Human Rights which consists of the Universal Declaration of Human Rights (UDHR)(1948) and the two conventions that explain how the UDHR should be implemented and monitored : the International Covenant on Civil and Political Rights (ICCPR)(1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966). Both conventions under the UDHR are binding on the countries that have signed and ratified them. South Africa has signed and ratified the ICCPR but not the ICESCR, in spite of the fact that the country recognises economic and social rights in its Constitution (Constitution of the Republic of South Africa (Act 108 of 1996), Chapter 2) (McQuoid-Mason & Dada 2011, p. 227).

3.3.1 The Universal Declaration of Human Rights (UDHR)

The Universal Declaration of Human Rights, generally agreed to be the foundation of international human rights law, is grounded in the premise that " all human beings are born free and equal in dignity and rights". The UDHR enumerates specific rights as articles. Many of the rights have been adopted in international and regional treaties that bind the states ratifying the treaties.

In December 1948 the UDHR made a commitment to upholding dignity and justice for all and has inspired a rich body of legally binding human rights treaties. These

treaties have become more focused and specialised over time and addresses concerns such as torture. (The Foundation of International Human Rights Law n.d.). The UDHR enumerates specific rights as articles. Many of these rights have been adopted in international and regional treaties that bind the states raifying those treaties.

Article 3 of the Declaration states that *everyone has the right to life, liberty and security of person.* Article 5 provides that *no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.* Further, *no-one shall be subjected to arbitary arrest , detention or exile* (Article 9).

3.4 RELEVANT INTERNATIONAL LEGAL STANDARDS

3.4.1 International Humanitarian Law and Human Rights Law

International humanitarian law is established by the international treaties that govern armed conflict (United Nations 2004, p. 3). The four Geneva Conventions of 1949 had been ratified by 188 states in 2004 and prohibit torture and other forms of ill-treatment (albeit in the conduct of international armed conflict (United Nations 2004). Two Protocols of 1977, additional to the Geneva Conventions, expand the protection and scope of these conventions. Protocol II (ratified by 145 states in 2004) covers non- international conflicts (United Nations 2004, p. 3). In all four Conventions, "Common Article 3" is found and is of particular interest for this study. While Common Article 3 applies to armed conflicts "not of an international character", it is generally taken to mean that no matter what the nature of a conflict, certain basic

rules cannot be abrogated (United Nations 2004, p. 3). The prohibition of torture is one of these and is a common element in international humanitarian law and in human rights law. Common Article 3 states:

> ...the following acts are and shall remain prohibited at any time and in any place whatsoever...violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;...outrages upon personal dignity, in particular humiliating and degrading treatment... (United Nations 2004, p. 3).

3.4.2 The United Nations

The United Nations has sought for many years to develop universally applicable standards to ensure adequate protection for all persons against torture or CIDT (United Nations 2004). The conventions, declarations and resolutions that are adopted by the member States of the United Nations (including South Africa), clearly state that there is no exception to the prohibition of torture and establish obligations to ensure protection against such abuses (United Nations 2004, p. 3). The most important of these instruments are the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration on Protection against Torture), the Code of Conduct on Law Enforcement, the Principles of Medical Ethics Relevant to the Role of Health Personnel Particularly Physicians in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment (Body of Principles on Detention) and the Basic Principles for the Treatment of Prisoners.

The international instruments cited above establish certain obligations that States must respect to ensure protection against torture. These include the establishment of effective legislative, administrative, judicial or other measures to prevent acts of torture (United Nations 2004). No exceptions are permitted or are to be invoked for the justification of torture. The act(s) of torture, including complicity or participation therein should be criminalized.

The UN prescribes that member states should ensure that education and information regarding the prohibition of torture is included in the training of civil and military law enforcement personnel and medical personnel. Member states should also ensure that competent authorities undertake prompt and impartial investigations into complaints or reports of torture.

3.4.2.1 United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984)

Of particular interest amongst the United Nations Conventions is the UN Convention against Torture and Cruel, Inhuman and Degrading Treatment or Punishment (CAT). This convention was written by the UN General Assembly in response to Steve Biko's death under torture and at the hands of the apartheid police (Muntingh 2011, p. 9). The convention was adopted by the General Assembly in 1984. CAT prohibits both torture and CIDT and argues that both research and experience has demonstrated that conditions that give rise to CIDT frequently facilitate torture and therefore the same measures required to prevent torture must be applied to prevent CIDT (Muntingh 2011, p. 20).

Acts that fall short of the accepted version of torture as defined in Article 1 comprise cruel or inhuman treatment under Article 16 of the Convention. Acts aimed at humiliating the victim constitute degrading treatment or punishment even where severe pain has not been inflicted. The distinction between torture and less serious forms of ill-treatment was introduced because some of the specific state obligations laid down in CAT were meant to apply to torture only namely, the obligation to criminalise acts of torture and to apply the principles of universal jurisdiction in this regard (Nowak and McArthur 2006).

Alleged offenders of torture should be subject to criminal proceedings if an investigation establishes that an act of torture has been committed. Further, if an allegation of other forms of CIDT is considered to be well founded, those offenders should be subject to criminal, disciplinary or other appropriate proceedings (Article 7 of the Convention against Torture).

CAT also calls for the education of all doctors and health professionals at the undergraduate and graduate levels in methods used for torture, the goals, the objects and the sequelae of torture as well as for the identification and treatment of victims of torture (Audet 1995, p. 611).

The duties for South Africa under CAT include the duty to prevent torture and CIDT (Article 2(1)) and the duty to criminalise torture in domestic law (Article 4). To elaborate, Article 4 places a duty on State parties to the Convention to enact legislation criminalising all acts of torture, attempts to commit torture and complicity or participation in torture. To make torture an offence under domestic legislation

gives recognition to the fact that torture is different from assault or attempted murder and that torture is an extremely serious offence. South Africa acknowledges the right not to be tortured or subjected to CIDT under the Constitution. Law against torture was enacted on 29 July 2013 under Act No.13 of 2013: Prevention of Combating and Torture of Persons Act, 2013. While CAT includes the prevention of CIDT into medical work and into the convention, the South African law against torture is limited to torture and does not however address CIDT.

3.4.3 Commission on Human Rights

The Commission on Human Rights is the primary human rights body of the United Nations (United Nations 2004). According to the Economic and Social Council, resolution 1235 (United Nations 2004, p. 6), the commission is authorised to examine allegations of gross violations of human rights and to study situations which reveal a consistent pattern of human rights violations (United Nations 2004, p. 6). The Commission stresses that all allegations of torture or cruel, inhuman or degrading treatment or punishment should be promptly or impartially examined by the competent national authority (Resolution 1998/38, United Nations, document A/37/40, E/4393).

3.4.4 Regional Organisations

Regional organisations have also contributed to the development of standards for the prevention of torture (United Nations 2004, p. 7). In this paper, the Inter-American Commission on Human Rights (1978) and the Inter-American Court of

Human Rights will be examined, primarily in recognition of the definition of torture as well as the right of any person making an accusation of torture to an impartial investigation/examination of his/her case (Article 8 of the American Convention on Human Rights (1978)). Rulings from the European Court of Human Rights are also considered to be of relevance. Finally, the African Commission on Human and People's Rights and the African Court on Human and People's Rights are examined.

The Inter-American Commission notes that an important obstacle to the effective prosecution of torturers is the lack of independence in investigations of claims of torture as investigations are likely to be undertaken by bodies acquainted with parties accused of committing the torture (United Nations 2004, p. 7, point 30).

The European Court of Human Rights reinforces the human right principle that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment" (Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms). The Court is able to consider the necessity of investigating allegations as a way of ensuring the rights guarenteed by article 3 (United Nations 2004, p. 8).

3.4.4.1 The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

The Committee argues that one of the most effective means of *preventing* ill-treatment by law enforcement officials lies in the diligent examination by competent authorities of all complaints of such treatment brought before them and, where

appropriate, the imposition of a suitable penalty. This has a strong dissuasive effect (United Nations 2004, p. 9). This convention also calls for special postgraduate training for persons to qualify as experts and interpreters in situations dealing with torture (Audet 1995, p. 611).

3.4.4.2 The African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights

Africa does not have a convention on torture and its prevention. Torture is examined on the same level as are other human rights violations, primarily in the African Charter of Human and Peoples' Rights, and was adopted by the Organisation of African Unity in 1981 and which entered into force on 21 October 1986 (Organisation of African Unity,document CAB/LEG/67/3, Rev.5, 21 *International Legal Materials,* 58 (1982)). Article 5 of the Charter states:

> Every individual shall have the right to the respect and dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

Victims of torture or an NGO can make a complaint to the Commission regarding acts of torture as defined in Article 5 of the Charter (United Nations 2004, p. 10).

3.4.4.3 The South African Human Rights Commission (SAHRC)

The South African Human Rights Commission was established in terms of the Constitution of the Republic of South Africa (1996) and the Human Rights

Commission Act, Act 54 of 1994, to promote respect for human rights and a culture of human rights; promote the protection, development and attainment of human rights and finally to monitor and assess the observance of human rights in South Africa (Constitution of South Africa (Act 108 of 1996) s 184 (1)).

In terms of the Constitution and legislation, the SAHRC has powers to investigate and report on the observance of human rights and also to take steps to secure appropriate redress where human rights have been violated (McQuoid-Mason & Dada 2011, p. 228). Doctors who feel that the human rights of their patients have been violated may complain to the SAHRC. Doctors who wish to bring human rights violations to the attention of the SAHRC, based on facts that they *bona fide* believe are true, are protected by the law of privilege even if the information is incorrect, unless the reporting has an ulterior motive, such as malice (McQuoid-Mason & Dada 2011, p. 229).

In previous years, the SAHRC has dealt with issues of police brutality, especially those involving illegal immigrants and refugees, but in recognition of the IPID as the primary investigating agency, it seeks to avoid overlap with and the "duplication of functions performed by the ICD [IPID]" (Bruce 2002).