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

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3.5 NATIONAL LAW

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

The Constitution of the Republic of South Africa, (Act 108 of 1996) is the supreme law of the land and all other laws and statutes have to conform to it. The Bill of Rights is contained in Chapter 2 and this Bill provides the human rights that apply to every one.

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

The following rights contained in the Bill of Rights are relevant to medical doctors and to patients. These rights include the right to be treated fairly and equally and free from discrimination (s9); life (s11); respect and protection of dignity (s 10); freedom and security of the person (s12). Further, torture is prohibited by the South African Constitution at (12)(i) and particularly where it involves physical force, constitutes a criminal offence.

Most of the rights listed are not absolute and may be limited under the Constitution, in terms of the law of general application to the extent that the limitation is reasonable and justifiable in an open and democatic society based on human dignity, equality and freedom (s36).

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

Prisoners, detainees and accused persons should be held in conditions of detention that are consistent with human dignity. This also implies that doctors should be aware that they must put their patients interests first and treat prisoners, detainees and accused persons in the same manner as they would treat any other patient. Prejudice should not be allowed to affect the treatment of these persons.

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

This act provides a framework for a uniform health system in South Africa based on the obligations imposed by the Constitution of the Republic of South Africa (Act 108 of 1996) and other laws of the national, provincial and local governments with regard to health services. It also harmonises the legislation governing health care services with the provisions of the Constitution and currently acceptable professional norms. The rights and duties of health care providers is dealt with in sections 19-20.

Where there are health-threats to the safety, well-being and security of communities,such as potential epidemics of an infectious nature, this act prescribes the mandatory duty of the medical doctor to report to the relevant authorities.

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

The amendment to Section 49 of the Criminal Procedure Act came into force at the end of September 2012. This amendment enabled the legal provision dealing with

the "deadly force" for arrest thus broadening the powers of the police to use deadly force (meaning force that is likely to cause serious bodily harm or death, and includes, but is not limited to, shooting at a suspect with a firearm)

> "provided that the arrestor is justified in using the force... that the force is immediately necessary...that there is substantial risk that the suspect will cause imminent or future death or grievous bodily harm if the arrest is delayed; or that the offence for which the arrest is sought is in progress and is of a forcible and serious nature..."

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

The use of force is defined in subsection 13(3)(b) of the above Act and applies to members of the South African Police Services. This subsection provides that " where a member who performs an official duty is authorised by law to use force, he or she may only use the minimum force which is reasonable in the circumstances"

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

Until July 2013, the South African Police Services (SAPS) was the only government department that had developed a policy on the prevention of torture (Muntingh 2011). This policy is known as the "anti-torture" policy (Bruce 2002) and guides the action of the members of SAPS.

Section 2 of this policy provides that:

> no member may torture any person, permit anyone else to do so, or tolerate the torture of another by anyone. No exception will serve as justification for torture- there can simply be no justification, ever, for torture.

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

This law was enacted on 29 July 2013. This was in response to section 12(1)(d) of the Constitution of the Republic of South Africa (Act 108 of 1996) and in fulfillment of South Africa's obligations as a State Party to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. This law criminalises the act of 'torture' but does not criminalise CIDT. It reinforces the equal and inalienable rights of all persons to freedom, dignity, justice and peace as well as the promotion of universal respect for human rights and the protection of human dignity. The Act also provides for the punishment of those guilty of torture but makes no mention of punishment for those guilty of CIDT.

3.6 ANALOGOUS LAW AND PROFESSIONAL GUIDELINES

There are certain instances where it is mandatory to report various forms of abuse. In other words, there are statutes in South African law where there is a duty imposed on the medical doctor to report suspected abuse of certain categories of patients and where failure to do so may constitute an offence under the relevant law.

3.6.1 Child abuse and neglect

Child abuse refers to the maltreatment (physical, psychological and/or sexual) of children which results in harm or potential risk of harm to the child. The Constitution of the Republic of South Africa,1996 (s28) provides that children have the right to protection from maltreatment, neglect, abuse or degradation. The Children's Amendment Act, 2007 (Act 41 of 2007)(s110) and the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act 32 of 2007)(s54) impose duties on medical practitioners and others to report instances of abuse and sexual offences against children (and mentally disabled persons). Thus doctors are obliged by law to report child abuse or neglect to the appropriate authorities, failure of which are guilty of contravening the Children's Act and may be prosecuted (s 305(1)(c)).

3.6.2 Elder Abuse

The Older Persons Act, 2006 (Act 13 of 2006) deals with aged or elderly persons. Doctors who work with older persons whom they suspect are in need of care and protection or are being abused have a duty to report their suspicions to the relevant authorities- either a social worker or Director-General of Social Development (s26).

3.6.3 Infectious Diseases

The Health Act (Act 63 of 1977) lists 32 diseases as notifiable and impose a duty on medical doctors to report these diseases and to keep records. This action is also required by the National Health Act 2003 (Act 61 of 2003). These diseases are

reported on a GW 17/5 form (Appendix III) and provide for patient details and a description of the disease.

While not directly related to the the abuse of persons, this legislation illustrates cases where confidentiality may be violated and sets a precedent beyond abuse cases providing notifiable complaints.

3.7 CURRENT REPORTING PROCEDURE FOR POLICE ABUSE

Orbinski, Beyrer and Singh (2007) argue that the inherent monopoly on the power as a state needs a method of monitoring to prevent them lapsing into tyranny. Monitoring systems should be independent of the state in order to be effective. Critically, very few cases of police brutality, torture or the excessive use of force by the police in South Africa ever results in prosecution of the accused (Muntingh 2012 ; Langa n.d.). In fact before July 2013, due to a gap in the South African law, torture was not criminalised and complaints of torture and CIDT were prosecuted or investigated as assault common or assault with intent to do grievous bodily harm (Langa n.d., p. 7). The new Prevention of Combating and Torture of Persons Act (Act No. 13 of 2013) does not criminalise CIDT so this action remains open to interpretation. At the time of writing, it was not known if anyone had been prosecuted for torture or CIDT under this Act.

3.7.1 The Independent Police Investigative Directorate (IPID)

IPID is a state funded oversight body that monitors the police. Currently, IPID is responsible for investigation of cases of police brutality (Burger 2013).This body aims to ensure independent oversight of the South African Police Services (SAPS) and the Municipal Police Services (MPS). IPID is also responsible for the conduct of independent and impartial investigations of identified criminal offences allegedly committed by members of the SAPS and the MPS and to make appropriate recommendations based on their findings (IPID 2013, p. x).

The Constitutional mandate of IPID is provided in Section 206(6) of the Constitution of the Republic of South Africa (Act 108 of 1996) which makes provision for the establishment of an independent police complaints body stipulating that:

> "On receipt of a complaint lodged by a provisional executive, an independent police complaints body established by national legislation must investigate any alleged misconduct of, or an offence committed by, a member of the police services in the province" (IPID 2013, p. 15).

IPID was preceded by the Independent Complaints Directorate (ICD) which was established in 1997 in terms of chapter 10 of South African Police Services, Act 68 of 1995 to promote consistent proper conduct by members of the SAPS and MPS (Bruce, Savage, & de Waal 2000; IPID 2013). The legal mandate of the ICD (which operated independently of the SAPS) was primarily to investigate all death in custody or as a result of police action, as well as criminal offences and serious misconduct alleged to have been committed by members of the SAPS and the MPS

(IPID 2013 ; Bruce, Savage, & de Waal 2000). IPID replaced the ICD in an effort to strengthen civilian oversight (IPID 2013).

When the IPID Act was promulgated on 1 April 2012, the ICD was renamed the Independent Police Investigative Directorate (IPID). The Independent Complaints Directorate thus became an investigation-driven organisation rather than a complaints-driven organisation (IPID 2013). The IPID , while functioning independently of the SAPS, resides under the Ministry of Police (IPID 2013).

In terms of section 28 of the Act, the directorate is obligated to investigate:
any death in police custody; death as a result of police action; rape by a police officer(whether on or off duty); rape of any person in police custody and finally, any complaint of torture or assault against a police officer in the execution of his or her duties. Investigations only take place upon receipt of a complaint.

Section 29 of the IPID Act requires members of the SAPS and MPS to report all matters referred to in section 28(1) of the IPID Act to the Independent Police Investigative Directorate immediately upon becoming aware of such matters and within 24 hours in writing. Members of the public as witnesses to or victims of police abuse are also able to make complaints or reports of such action.

The current reporting process is that, once a victim has been been assaulted, if not in custody, he should seek medical attention and have all injuries documented. The victim should then engage a legal representative and lay a charge of assault at the nearest police station. Following this a report is made to IPID (on an IPID complaint

form (APPENDIX I)) who investigate the police (mis)conduct. Usually a compensatory amount for damages is paid out to the victim as a civil claim (Langa n.d.,p. 42; Yusuf Abramjee, Crimeline, 2012) but it would seem from the IPID report that rarely any further action is taken against the perpetrators (Langa n.d, p. 41 ; Burger 2013).

A flaw (as previously identified)with the reporting process is that the IPID complaints form does not differentiate between assault, torture or CIDT. This general categorisation raises questions for the process of investigation since the crimes are very different and have different implications for prosecution. Further, since there is now a law criminalising torture, will a new complaints form be developed that will facilitate accuracy of complaints and appropriate investigation and prosecution?

CHAPTER 4

4.1 ANALYSIS AND CRITIQUE

This research report questioned whether medical doctors have a legal or ethical *duty* to report police brutality (or as it is defined in this report, cruel, inhuman or degrading treatment or punishment as a human rights violation). It also examines the right to dignity and security of persons. The rationale for the research is that medical doctors are often the first to see evidence of CIDT when they are consulted by victims for treatment for injuries incurred subsequent to police brutality. Further, it is argued that the prevalence and incidence of CIDT by the police is not fully understood since statistical indicators as provided by IPID are most likely inadequate and unreliable. This may be because the statistics are based only on complaints that are made against the police and investigated by IPID. Not all victims of police brutality complain to IPID. Complaints by victims are rare (although events are common) because there is a real fear of reprisal (the victims are expected to complain to and be investigated by the very agency that perpetrates the mistreatment) or because there is little faith in the investigative process (Moreno & Iacopino 2012). Victims may also be ignorant of the reporting process (Langa n.d., p. 31); or do not have the financial means for representation. Further, many cases are either not prosecuted or are charged as lesser crimes, such as common assault leading to a lack of faith in the process of justice (Langa n.d, p. 15; Muntingh 2011, p. 10). Since current statistical indicators are dependent on complaints being made, this method of monitoring would indicate that the current available data may not be truly reflective of

the reality of CIDT. It would seem to follow then that there is no truly effective and reliable method of monitoring police brutality.

Finally and most importantly this research argues that CIDT is a human rights violation. The medical doctor as an advocate for human rights has a role to play in reporting police abuse by accurately recording and reporting evidence of alleged abuse, thereby helping to prevent further abuses of human rights. The most effective method of preventing human rights abuse is with effective and reliable monitoring (Pothier 2013; Moreno & Iacopino 2012). Also, where a country's police force is subject to strong civilian control and oversight it tends to work within the law, to respect human rights and to combat crime effectively (Pothier 2013).

The SAPS policy on the Prevention of Torture and Treatment of Persons in Custody of the South African Police Services (n.d.) prohibits torture but makes no mention of CIDT. When one considers the distinction between torture and CIDT made by Nowak and McArthur (2006) as one of personal liberty then one has to consider the brutality or excessive use of force, outside the conditions of detention, as CIDT. The amount of force that the SAPS may use is defined in section 13 of the SAPS Act (South African Police Services Act, 68 of 1995) and is referred to explicitly in section 13 as "where a member who performs an official duty is authorised by law to use force, he may only use the minimum force which is reasonable in the circumstances" (Bruce 2002). The use of dogs to intimidate or overpower, or the dragging of an arrestee behind a vehicle is surely not minimal or reasonable.

I do not argue that legitimate and proportionate force should never be used in policing. There are clear guidelines for the use of force, provided that it is reasonable and has a purpose, for example, where a policeman has to defend himself, protect others or prevent a crime in progress. The law provides for the use of lethal force in these circumstances. I am arguing against a deliberate, unlawful, excessive use of force which does much more than control a suspect. The enforcement of the law by the police often demands the use of force and sometimes lethal weapons but the force used should be proportionate to the policing task. Where lethal force is used, there should also be proportionality. Only excessive use of force is considered as CIDT but whether the force is considered excessive or lawful is dependent on the proportionality in the particular situation. Nowak and McArthur (2006) argue that the principle of proportionality requires that the use of force be legal under domestic law and regulated by police codes; that the use of force should aim at a lawful purpose and finally that the type of weapons used and the intensity of the force applied should not be excessive but necessary to achieve the lawful purpose.

There are no specific ethical guidelines or laws, nationally or internationally, that prescribes a duty for the medical doctor to report incidents of CIDT that he or she has treated or been witness to. The exception is the WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment. This resolution was formulated in recognition of the fundamental human rights of dignity and value of the human person as well as the right not to be subjected to torture or CIDT (Article 5 of UDHR 1948). There are also a number of guidelines and laws that prohibit torture and CIDT and condemn the complicity of medical doctors with torture and CIDT.

In this report I contend that medical doctors who treat the consequences of CIDT are both tolerant and complicit by not reporting or acting against this abuse. The most common form of complicity is passive acceptance (International Dual Loyalty Working Group 2002). The WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or CIDT (2007) recognises that the absence of documenting and denouncing acts of torture and CIDT may be considered as a form of tolerance thereof. It could thus be interpreted that by accepting or condoning the police actions they are being passively acquiescent.

The ethical dilemma raised by this argument is whether it is morally wrong for the medical doctor not to report incidents of police brutality or CIDT. This invokes a discussion linked to the debate surrounding moral responsibility for acts as opposed to omissions. Is not acting against torture the same as participating in torture? The Roman Catholic Church claims that an omission by definition is not simply any inaction but a morally culpable inaction (Gillon 1986) and therein is my argument. By not acting against known police brutality, torture or CIDT, the medical doctor is morally culpable by being complicit in not denouncing the human rights violation. Following this reasoning, by not acting the doctor is acting but not positively. The 'inaction' does not right the wrong. International, national guidelines and law as well as the very nature of the profession itself, would expect some positive action in the protection of society and in the promotion of human rights. Gillon (1986) elaborates that additional moral information, is required before an inaction can be described as an omission. In other words, the doctor should know or at the very least be aware that police brutality or CIDT is a human rights violation and that it is morally wrong to condone, or not intervene or take action against such a violation. Arguably the level

of culpability is changed depending on the law. Ignorance of the law is not a defence in civil law. Since there is no law compelling the medical doctor to report police brutality or CIDT we have a situation in the current atmosphere that there is no actual crime in failing to report using civil law. Thomas Aquinas (as cited in Gillon 1986, p. 127) argued that an omission means failing to do good, albeit not any good, but only the good that one ought to do. Using Aquinas's idea of acts and omissions the fact that there is such a serious omission in the law makes it even more imperative that we have a law that requires reporting. While the duty for the medical doctor to act against police brutality and CIDT is not legislated the medical doctor should have some knowledge of human rights and as a consequence, by not acting, would be morally culpable. The recognition of human rights is not a condition that one should prevent every violation of every human right whenever and wherever it occurs (Sen 2004). It is, rather, an acknowledgement that if one is in a plausible position to do something effective and meaningful in preventing the violation of that right, in those circumstances, one does have an obligation to consider acting against that violation (Sen 2004). I interpret an omission as failing to act to do good when one should act, especially where by not acting, harm is perpetuated. It is morally impermissible for a medical doctor to participate in torture or CIDT it should therefore be morally impermissible for a medical doctor to fail to intervene, act, advocate or agitate against these violations.

On the other hand, it is arguable that when a person fails to act (or acts as the case may be) from ignorance, he is culpable for his inaction (omission) from which he acts. Rosen (2003) argues that this principle, his 'parity thesis', holds whether the actions are not done from 'factual ignorance' or from 'moral ignorance' (Rosen 2003,

p. 64).The reasons for omission due to 'factual ignorance' would be where the medical doctor could argue that he did not know that there was legislation or a guideline; that the national medical associations did not keep him updated or even that s/he did not know that a human right was being violated. S/he could even argue that s/he was not aware that there was a duty for the medical doctor to uphold or protect or advocate for human rights. This would be a sad indictment of the current undergraduate medical ethics and human rights training as well as the continuing medical education at a post graduate level.

The failure to act from 'moral ignorance' would only hold if the medical doctor truly did know what to do when presented with a case of CIDT, in other words, that he did not know that people have certain rights and that the doctor in turn has certain duties. One can fail to know that police brutality is cruel and inhuman treatment and is wrong. One can also fail to know that one has a responsibility to act against this action and halt its perpetuation. The failure to act from 'moral ignorance' is not defensible in this case and I argue that in spite of this 'moral ignorance' the doctor remains morally culpable, because by his actions and his lack of regard, he is not acknowledging the 'humaness' of the victim. I argue that the doctor has not considered the rights and wrongs of either the action by the police or his own. Also full consideration has not been given to the consequences of the omission.

Equally, though there will be times where an omission occurs neither from 'factual' or 'moral ignorance' but because it is a path the medical doctor consciously chooses. The doctor may choose not to act for fear of reprisal and intimidation by the police.

S/he may also just not want to "create work" for her/himself. Currently the completion of the J88 form is time consuming, not adequately remunerated and may require the doctor to give evidence in court. This would mean time away from practice and loss of earnings and most doctors resent the whole process and do not want to get involved. Rosen (2003, p. 74) argues that "it is unfair to blame someone for doing something if he blamelessly believes that there is no compelling moral reason not to do it" and so equally, to paraphrase, it would be unfair to blame someone for *not* doing something if he blamelessly believes that there is no compelling moral reason to do it. I argue, in this case that the doctor is only acting in his/her own best interest and not in the best interest of the patient (as required by national and international medical ethical guidelines) or society as a whole. Further, if there were professional guidelines and legislation requiring the reporting of police brutality and CIDT (as there is for other categories of abuse) this would not be contentious.

Until 2013 there was no law in South Africa that criminalised torture and CIDT. The Constitution of South Africa (1996) in sections 12(d) and 12(e), ensure the right of all persons to be free from torture and CIDT providing for everyone to be free of torture. South Africa has also signed (1993) and ratified the UN Convention against Torture and CIDT (CAT) in 1998. A requirement of signing and ratifying the CAT is that the State implements legislation criminalising torture and CIDT. On 29 July 2013 the South African parliament passed the Prevention and Combating of Torture of Persons Act which officially criminalises torture (Langa, n.d., p.9). In terms of Article 4 of the Act, the state shall make acts of torture punishable with appropriate penalties that take into account the seriousness of the crime. A major flaw (although it is not required by CAT) in this new Act is that it does not mention CIDT nor does it

mention the conditions under which torture takes place. It has already been established that the right not to be tortured is absolute. The CAT definition of torture is briefly, an "aggravated form of cruel, inhuman or degrading treatment or punishment" (Nowak & McArthur 2006) and makes no mention of the conditions of personal liberty that may characterise CIDT.

Since medical doctors have been involved in human rights abuses internationally (for example, South Africa, Turkey (International Dual Loyalty Working Group 2002)) , it has become more and more important both nationally and internationally, for medical professional associations to ensure that medical doctors respect the rights of vulnerable patients, especially those with constrained liberty. The HPCSA provides that the medical doctor should protect and serve the public and also prescribes the doctor's duties in keeping with the Constitution of the Republic of South Africa. The medical doctor should recognise the intrinsic worth and dignity of his/her patient and uphold human rights. How does the doctor take a history, examine a patient injured by police abuse and then not respond to what is an obvious violation of the most absolute human right- that one has the right not to be tortured or subjected to CIDT? It is redolent of the passive acquiescence of medical doctors, when faced with similar situations under apartheid. This behaviour was defended by MASA as complacency rather than complicity (Chapman and Rubenstein 1998). Whether it is complacency or complicity, the outcome is the same – human rights are violated. By not responding the medical doctor is as guilty as the perpetrator in the perpetuation of these human rights violations since by keeping quiet he is actually condoning the actions. While not actively complicit in the abuse or brutality, arguably the most

common form of complicity is passive acceptance (International Dual Loyalty Working Group 2002).

The right not to be tortured or subjected to CIDT is not the only right that is being violated by the police. Persons also have the absolute right to dignity, which has universal application and cannot be derogated from (Muntingh 2011). Dignity not only implies respect for the autonomy of a person, but also the right of every person "not to be devalued as a human being or treated in a degrading or humiliating manner (Muntingh 2011, p. 12). Muntingh (2011) argues further that the right to dignity exists not only to protect the individual against adverse conditions affecting them but it also imposes a positive obligation on the State to act proactively in order to prevent the individual's dignity from being negatively affected. Thus the right to dignity is at the heart of the right not to be tortured or subjected to CIDT.

One of the central lessons arising from the South African Truth and Reconciliation Commission's examination of the health sector was the need to address the human rights obligations of health professionals (London and Baldwin-Ragaven 2006). The Truth and Reconciliation Commission recommendations for the health sector transition following apartheid prescribed the inclusion of human rights in the professional guidelines. While both the HPCSA and SAMA follow the TRC recommendation and prescribe that doctors should respect and promote human rights, these prescriptions are vague there is no specificity on what to do when the medical doctor recognises that the human rights of a patient have been violated. The

guidelines advocate the reporting of knowledge of a human rights abuse, but do not describe how, when, where or to whom.

Human rights are usually state obligations but medical doctors in the state-employ or as private providers of healthcare have a social responsibility to ensure, not only that they themselves do not violate the rights of their patients, but that the human rights of their patients are not violated. No definitive action has been described by the law or medical professional bodies to guide action to be taken by doctors when they are witness to police brutality. There is therefore, no legal or professional obligation to report police abuse in spite of police abuse being a human rights violation, with or without cause.

We are starting to recognise the human rights violations implicated in police brutality and CIDT and need to agitate and advocate for legislation to tighten the obligation to report which is currently only a moral obligation. Advocacy and agitation should also influence the law so that it also presents a reliable place to report to.

A 'duty to report' can be statutory, moral or both. The HPCSA describes a duty as an obligation to do or refrain from doing something. If there is no duty to report CIDT as a human rights violation is there a duty not to report CIDT? The recognition that human rights are being violated demands some type of moral action. While human rights can be seen as "primarily ethical demands" (Sen 2004, p. 319), they are not principally "legal", "proto-legal" or "ideal-legal" commands. Sen (2004) argues further

that human rights can inspire legislation. This may depend on the significance of the freedoms that form the subject matter of these rights and these should meet some "threshold conditions" of i) special importance and ii) social influence ability (Sen 2004, p. 319). Human rights also generate reasons for action for those (medical doctors) that are in a position to help in the promoting or safeguarding of the underlying freedoms (Sen 2004, p. 319). The obligations that are induced involve the duty to give reasonable consideration to the reasons for action (Sen 2004, p. 319). Public recognition, agitation and the monitoring of violations can be part of the obligations generated by an acknowledgement of human rights (Sen 2004, p. 320).

Sen (2004, p. 320) argues that a "pronouncement of human rights includes an assertion of corresponding freedoms" and moral and ethical duties. He elaborates that the human right of not being tortured stems from the universal freedom from torture for all, but includes an affirmation of the need for others to consider what they can reasonably do to secure the freedom from torture for any person (Sen 2004, p. 321). An agreement on human rights involves a firm commitment to give reasonable consideration that follow from that ethical endorsement (Sen 2004, p. 322).

London and Baldwin-Ragaven (2006) propose that the ethical commitments of doctors to maximise the well-being of those in their care implies a unique responsibility to be advocates for the protection and promotion of human rights. Advocacy on behalf of patients means that doctors should act to protect the interests of patients before they are harmed or when they have been harmed by the conduct of others or by international policies or laws (McQuoid-Mason & Dada 2011, p. 15).

Where medical doctors recognise that the human rights of their patients are violated, medical doctors can act as advocates to promote and fulfil human rights. "Doctors as advocates" is nothing new to South Africa. Doctors acted as advocates for patients' rights under apartheid. Following the TRC recommendations, doctors should continue to be advocates for patients and for the promotion of human rights, not only with regard to socio-economic issues, access to health-care and medicines, but also and especially to prevent acute and chronic physical and psychological injury consequent to human rights violations such as police abuse. There is no specific law or guideline dealing with advocacy on behalf of patients but in most ethical codes doctors are expected to accept the role of advocates on behalf of their patients (McQuoid-Mason & Dada 2011).

One of the problems with measuring police brutality is credibility, both on the part of the victim as well as the part of the police. It is also often difficult to assess whether an incident amounts to torture or CIDT. It is common for an arrested person or a victim to allege that his/her injuries were the result of excessive force by the police, but is just as common for the police to assert that the injuries were incurred because the person was resisting arrest or because they had to be forcibly restrained. In such cases it is difficult to ascertain the truth with certainty. Bruce (2002, section 3) posits that the problem is aggravated, not only because there are at least two competing accounts of the incident, but also because "the people making the allegations [of abuse] are often of low social status, and might in general have difficulty in presenting their version of events in a manner which is more credible than that presented by the police".

Orbinski et al (2007, p. 698) argue that effective monitoring methods must by their very nature, be independent of the state. Systems for the lodging and investigation of complaints are usually controlled by the police (Bruce 2002). While IPID is apparently an independent investigative directorate and a civilian oversight body, it still falls under the Ministry of the Police. In February, 2014, the Minister of Police, Nathi Mthetwa appointed the new head of IPID (IPID 2014). While the Minister of Police may be committed to effective and clean policing and the elimination of human rights violations by police officers this action does raise questions of the independence of the Directorate. It would seem that a problem of dual loyalty exists within IPID itself thus making reporting even more difficult, when one considers that one is already reporting abuse to those that both perpetrate and investigate the brutality.

There are apparently also differences in the way that complaints may be lodged and the charges allocated. In other words, there is no neutral, consistent protocol for the lodging of a complaint or for the investigation thereof, or for the charge to be made (Langa n.d.). It would seem therefore, that without consistent and effective recording, documentation, proof, and/or witnesses it would be very difficult to determine whether incidents of police brutality actually occur. This therefore would be where the medical doctor may be of use to both the police force and to the alleged victims. In other words, the medical doctor, independent of the police force, police sub-culture or governance of the police force can examine the veracity of the allegations.

As recommended by the WMA (2007) medical organisations can adopt and disseminate principles that specifically address protocol regarding police brutality. Equally, because medical doctors are often the first to be consulted by victims of police brutality, they can play a key role in terms of exposing or hiding police brutality as well as in the documentation of cases of abuse, highlighting the brutality and thereby preventing further brutality.

This report proposes that since there are irregularities in the examination, recording and documentation of police brutality that a process that is standardised, consistent and reliable should be implemented. As part of routine practice, at consultation, it is necessary for medical doctors to take a patient history and then do a physical examination, prior to the initiation of treatment. Where a patient has been subjected to police brutality the history and documentation may be both crucial and necessary for further investigation should a victim take action against the police. Many doctors are unaware of their obligations in this area. To make matters worse these obligations are vague in current guidelines and law. The obligations are currently broadly moral from a human rights perspective following the current professional guidelines. Thus reporting police brutality and the role of doctors is largely hit and miss and at worst is ignored. Doctors may also not have the requisite skills to proceed with appropriate action effectively and meaningfully.

Currently, where a victim has been assaulted (as in common assault or assault with intent to do grievous bodily harm) a form, describing the victim's injuries and a brief history is completed by the medical doctor. This form is the J88 (Appendix III) and

the police are dependent upon this form in the investigation of a complaint of assault. While generally acknowledged as appropriate for the purposes for the purposes of prosecution (evidentiary issues) (Martin and Artz 2007) it is felt that this form may minimise the egregious violation of human rights that constitutes torture and CIDT. For this reason a specific protocol should be implemented. The Istanbul Protocol (IP) (Appendix II) has been identified as a guiding document which makes this process of recording an incident of police brutality easier and consistent. The Protocol prescribes guidelines for taking a detailed history of the alleged abuse. It also regulates precisely the performance of a physical examination, ensuring effective documentation that could be used as evidence should a prosecution take place. This history and examination would verify and substantiate the allegations of abuse. It would also serve to negate the allegations where the injuries are inconsistent with said allegations. Thus the document could serve either the victim or the police. By following the IP doctors can correlate the history and injuries and thereby validate, using a careful and thorough clinical examination, the victim's allegation of police abuse. It would provide a strong medical testimony based on aspects of the clinical history and physical examination. Doctors could be trained in the protocol and have the guidelines and documents accessible to enable reporting officially and effectively especially where an investigation and prosecution may be initiated. The Istanbul Protocol is more comprehensive and allows for documentation specific to torture and CIDT. In this way doctors would be reporting cases of the alleged use of unlawful and excessive force by police and more reliable data would be collected. An independent authority trained in the assessment of torture and CIDT would determine whether the injuries were the result of excessive force. Equally, where the victim wished to lay a complaint against the police effective documentation would

exist which would facilitate this action. It would be even more effective if the IP were adopted in South Africa as part of the medico-legal requirements that a doctor should complete, that it would lead to legislation.

One problem with the Istanbul Protocol is that it does raise issues of patient confidentiality and informed consent. It is a requirement that the victim is informed of the IP and its meaning prior to the interview and physical examination and that it may also be used as part of data collection. Victims are required to sign consent to the examination and report. In recognition of the rights to autonomy and self-determination victims have the right to refuse consent. Many patients may not wish to consent to this process for fear of being identified or for fear of reprisal or any other reason. They may also not want to make a complaint against the police force or want their case investigated, not least because of the South African history of medical complicity with the police (Marcus 1985). The victim's right to autonomy and self-determination is also a human right (as well as a basic ethical principle) and thus should be respected. To this end I draw on the recommendation made by Martin and Artz (2007) in their Sexual Offences submission that:

> **Victims should be given the option of undergoing the full forensic examination, including the collection of medical evidence, and having it kept at the health care facility for a period of up to 90 days to enable the victim to decide whether or not he or she would like to report the incident**

In these cases an option for post-hoc consent before reporting should be an option. In any case the patient history and examination should be retained by the medical doctor according to current record keeping requirements (HPCSA, Booklet 14).

An unfortunate consequence of not having cases added to the data collection would skew the data. To avoid this it is proposed that reporting should be performed on two levels. It is to this end that in addition to the forensic examination and documentation prescribed by the IP that a form of epidemiological data collection could also be implemented.

It is mandatory for medical doctors to report certain infectious (notifiable) diseases. In the same way, where victims claim the right to confidentiality or do not wish to provide consent to the IP, using basic epidemiological principles, cases of police brutality could still be reported. The cases could be reported to the Department of Health, SAHRC or to an independent human rights representative on the main professional body, HPCSA, who would be assigned the task of dealing with all human rights issues. SAMA has a Human Rights, Ethics and Law Committee that in implementing and promoting a human rights culture in the health sector could also manage the reports. The case information would be collected anonymously on a form similar to the current GW 17/5 for infectious diseases (Appendix IV). The history and examination could be carried out following the IP but the victim's identity will not be disclosed without the victim's consent. The victim could be ascribed a patient number based on the reporting doctor's medical practice number, an area code for the practice and thereafter sequential numbers for each case. These actions would

obligate the medical doctor to report police abuse and would assist in the fulfilment of ethical duties to protect and promote human rights and to protect the society that they serve, and resist all attempts to deny human dignity.

Further, it should also be noted that IPID does allow witnesses to report police brutality and this may be an option for reporting. This option does not allow for extensive evidentiary examination and documentation. Doctors as witnesses to the injuries sustained could make complaints to the IPID using the form provided by IPID (Appendix I). The use of this form to make a complaint would require the victim's permission, which again may not be possible as a result of aforementioned reasons.

CHAPTER 5

5.1 RECOMMENDATIONS

International guidelines and law prohibit torture and CIDT and any role that may implicate the medical doctor in the perpetuation of such. There is no explicit and consistent reference in professional codes of ethics or legislative texts prescribing an ethical or legal obligation or duty for the medical doctor to document, report or denounce acts of torture or CIDT. The WMA Resolution (2007) has been the most useful document in recommending actions that should be taken by national medical associations. It is assumed that by adopting these recommendations that national medical associations will encourage their members to follow the prescribed principles in acting against torture and CIDT. The following recommendations are based on the WMA resolution (2007) as well as findings in other literature.

5.1.1 Education and Training

Human rights play a fundamental role in the training of medical doctors. Factors affecting human rights practice, such as knowledge, skills and attitudes are of importance. Knowledge and competence and proficiency in the field of national and international standards to which the practitioner will be held accountable should be a requirement for qualification and also for registration. The neglect and failure of

human rights and ethics in the medical profession has resulted in an ad-hoc nature of teaching, a lack of examinability of ethics, inconsistency of teaching and the failure to integrate human rights into curricula (Oosthuizen & Verschoor 2008, p. 36).

Educating and training medical professionals does not only mean that they must be familiar with the contents and the functioning of their relevant fields of speciality, but that they must be well-educated in the ethical principles/aspects as well as the legal requirements involved (Oosthuizen & Verschoor 2008, p. 36). Medical law and medical ethics/bio-ethics must therefore play a very important role in training, education and continued development programmes of medical doctors (Oosthuizen & Verschoor 2008).

5.1.1.1 Training of medical students

The most fundamental responsibility that a medical doctor has regarding care of patients is to ensure that s/he has the skills and training to treat, care for and promote health and well-being. Medical care should be holistic and part of that holistic care should include an awareness and consideration for human rights. As such, medical students should be trained to recognise that passive participation or acquiescence in violations of a patient's right is a breach of loyalty to the patient.

National and international medical codes and covenants on torture and CIDT are not enough to ensure that medical doctors are aware that these actions are against the ethical codes of medical doctors. Health care students should be educated explicitly on active engagement with human rights, going beyond simply considering health to be a human right and ensuring the recognition of any behaviour which demeans human rights.

The education and training of doctors to enable them to know human rights and recognise their violations will produce a profession that is more caring; strenghten realtionships between the medical profession and society and ensure a political sytem that is accountable.

Training in ethics and human rights is already enacted in most South African medical schools. The subject of bioethics and human rights could become an examinable part of the medical training programme. Medical students should also be encouraged to spend electives (on rotation) at a human rights organisation such as Physicians for Human Rights or Medicins' Sans Frontiers' may be more beneficial and "hands on".

5.1.1.2 Continuing medical education

Inadequate knowledge of the principles of human rights can contribute to the inability or unwillingness on the part of doctor's to bear witness. It can also lead to physician

tolerance or acquiescence or tolerance of human rights violations (Orbinski et al 2007, p. 703). Knowledge of human rights principles, in effective documentation and bearing witness can be the first step in addressing and challenging the social, political and economic forces that constrain human dignity (Orbinski et al 2007, p. 703).

Medical associations and professional bodies can expand and magnify the effectiveness of the medical doctors' work by educating their members about the content and significance of well recognised medical and international ethical principles and incorporate them into their own codes. They should also support and protect members who abide by them and deal appropriately with those who violate them. Reporting violations are often the only means that medical professionals have to end these violations.

The WMA (2007) also recommends that national medical associations promote the training of physicians on the identification of different modes of torture and CIDT, in recognising physical and psychological symptoms following torture and in using the documentation techniques foreseen in the IP to create documentation that can be used as evidence in legal and administrative proceedings. They should also promote awareness of the correlation between the examination findings, understanding torture methods and the victims' allegations of abuse. National medical associations should also ensure that physicians are made aware of the victim's rights to informed consent, autonomy and confidentiality and should use the necessary safe-guards to prevent the endangerment of the victim.

5.1.2 The Istanbul Protocol

The WMA (2007) recommends that the Istanbul Protocol be used as a tool for the collection of data pertaining to the documentation of alleged police brutality, torture or CIDT. The Protocol can be modified to suit South African requirements but should retain the minimum standards for physical examination, history taking and documentation. It is proposed that the IP should be the basis for reports leading to prosecution. The current J88 (a medico-legal document currently used to document assault) (Appendix III) can be modified to this end. This Protocol would assist in either implicating or vindicating the police with abuse.

Before implementing the IP or a modified version thereof, it is necessary to consider the role change of the medical doctor, in that an investigative perspective will be added to a traditional treatment oriented focus. Specific training will be needed to ensure that the process is carried out effectively as well and it is possible that not all medical doctors will be willing to take part. Alternatively, certain doctors trained in human rights and the IP could take responsibility for the management of victims.

5.1.3 Epidemiology

Following the principle that there is always a moral duty to report violations of human rights but the IP cannot always be followed, there should be some type of

anonymised epidemiological data base. While this will not lead to prosecution, it may lead to a 'raising' of moral consciousness. Reporting and documenting police brutality allegations with substantial empirical data may provide the reasons for justification for making the police more accountable.

Expertise, knowledge and the application of epidemiological principles can be used to collect and document evidence of police brutality in order to give credibility to current statistics concerning the incidence and prevalence of police brutality and CIDT. Equally, these principles can act as vindicators police practice thereby protecting the police.

In order to protect a patient's identity or where a victim does not wish to make a formal complaint to IPID, a form similar to that used to report infectious diseases could be implemented (GW 17/5, APPENDIX VI). This form would be anonymised but would record the date, place and a description of the injury incurred. It would be a valuable tool in the collection of quantitative data and would provide a more realistic indication of patterns of abuse. Further, this doctor's role could act as a filter for IPID, in other words, filtering truthful allegation from false accusations. The doctor would act as a gate-keeper, providing only medically evidenced and documented cases for IPID investigation. This form would not preclude the necessary history and examination required medico-legally for the doctors' own records.

An approach, consistent with the spirit of the protocols, declarations and conventions of the WMA and the UN principles of Medical Ethics, would be for professional associations and other professional organisations to name and appoint a human rights representative on their bodies (Audet 1995). Then when police abuse has been identified by a medical doctor, a copy of the report could be sent to the representative and this could be collated against the reports received by IPID.

5.2 CONCLUSION

"It is our duty as doctors to reject any attempt to bend our ethical aim to do no harm and to alleviate suffering. We should also actively resist any attempt, however powerful, to corrupt the idea of human dignity" (Justo 2006, p. 1462). The most basic and fundamental premise of a human right is to respect and protect individual persons. For health professionals a human rights framework provides "a moral compass and a blueprint of a just and humane social order that at its core articulates the principles of dignity and equality of every human being" (International Dual Loyalty Working Group 2002). The right not to be tortured or subjected to cruel, inhuman or degrading treatment or punishment is a 'settled precept' as is physician complicity with torture and CIDT (Miles 2012, p.195). There is no justification for such treatment, ever. Arguably the use of lethal force (usually by means of firing a fire-arm) for the prevention of a crime, in self-defense or to prevent injury to others may be necessary and there are provisions for the use of this force in South African law. The deliberate, systematic, unlawful, unreasonable assault of a person, with the

intention of causing harm and humiliation is not included in the law and should be recognised as wrong.

One of the most effective ways to break the cycle of impunity is through the effective medical and legal investigation and documentation of torture and ill-treatment. Forensic medical evidence is often one of the most powerful forms of material evidence to corroborate a victim's allegations of abusive treatment. Orbinski et al (2007, p. 703), argue that our responsibility as human beings and as health professionals is to bear witness honestly to the reality of inhumanity and to speak out against the "moral dearth" of political inaction or complicity. "Speaking out might not definitely save lives, but silence certainly kills" (Orbinski et al 2007, p. 703). Doctors as humanitarians and because of their societal status do have the power and position to speak out against violations of human rights and to advocate for society, socio-politically, economically and from a human rights perspective.

While not actively complicit in the actual abuse or brutality, arguably the most common form of complicity is passive acceptance, or silence in the face of human rights violations. Where medical doctors are aware of police abuse but say and do nothing, either because they believe they are powerless or because they think it is not their concern, they are essentially complicit in human rights abuses.

With one identified exception, international and national professional codes do not guide doctors in situations where they are witness to the consequences of police

abuse. The duty of the medical doctor to speak out remains vague although the prescriptions to serve humanity are not. In the past medical doctors mainly relied on the ethical guidelines set out by the HPCSA, international codes, declarations and common ethical principles. Ignorance of these codes and guidelines could lead to legal and ethical accountability as well as conviction for unprofessional or unethical conduct (Oosthuizen & Verschoor 2008, p. 36). The result of changes in legislation and guidelines(Bill of Rights; Act No. 13 of 2013) require that medical doctors need to be trained in human rights, medical ethics and medical law. Medical law and bio-ethics must therefore play a role in training, education and continued development programmes of doctors (Oosthuizen & Verschoor 2008, p. 36).

Knowledge of human rights principles, documentation and bearing witness can be the first step in addressing the social, political, and economic forces that constrain human dignity. The medical doctor as a witness serves the patient first, and by so doing, honours the dignity of all people and act as an advocate for victims. By becoming aware of provisions in the South African Constitution, in international human rights legislation as well as in ethical codes of conduct, health professionals can begin to address human rights violations and ensure positive conditions for people's health.

At many levels, physicians can make a difference as advocates as well as clinicians. Physicians can take the initiative where human rights have been violated. They have knowledge and skills that can enable them to act positively to protect human rights. Quantitative monitoring of police violence and torture in South Africa is inadequate

and unreliable and as such has not been used to inform or advocate for required changes in South African policing. Doctors can play a very important role in gathering reliable data that will both facilitate research into police abuse, providing valid statistics and in monitoring police abuse.

A common medical principle is that prevention is better than cure, thus as far as police brutality goes, prevention should become the highest attainable goal. Medical doctors and their professional associations are duty-bound to make use of their professional status and medical and scientific authority on issues of medical ethics and human rights (Audet 1995). If medical doctors remain silent and do not oppose police brutality and torture they are complicit and also endanger the trust that society puts in them. Health professional associations should also be encouraged to work together with human rights organisations more intimately.

It is clear from the examination of the law and guidelines in this report that while there is a duty to report abuse in other categories, there is no legal or ethical *duty* for medical doctors to report police abuse specifically either from a statutory or a professional point of view. The moral duty to take action against police abuse across local and international guidelines is broadly defined. The HPCSA and SAMA guidelines do however provide that there is a duty to respect human rights and to report violations of human rights. The excessive use of force or police brutality is a violation of human rights in that it violates the right to dignity, security of person and the right not to be subjected to torture, cruel, inhuman or degrading treatment or punishment. Victims of police abuse inevitably require medical attention and the

doctor has a duty to treat that victim without judgment and discrimination. An effective response to police abuse would be a concerted action and commitment on the part of doctors to act against it. Sen (2004, p. 343) argues that there are three aspects to advancing the cause of human rights namely recognition; agitation and advocacy and finally legislation. Equally, I apply these three aspects to a violation of a human right.

We have recognised that police brutality and CIDT violate human rights. In order to protect and uphold the human rights being violated, it is now up to medical doctors, consistent with the integrity and legitimacy of the profession, to agitate and advocate for a duty or obligation to report police brutality. Reporting and documenting the brutality would help to monitor the violations of the rights and thereby generate effective social pressure. This agitation and advocacy may lead to legislation to report police brutality and also change police practices. Where the police force escapes civilian control, it usually acts with impunity, allowing human rights abuses and excessive forces to flourish (Pothier 2013). All of this constitutes a worrying threat to the rule of law and the stability of democracy (Pothier 2013).

As health professionals, doctors should be concerned with the protection of human rights, as defined by basic humanitarian law (Audet 1995). The consequence of the abuse of human rights with police brutality is not the acute injury but the chronic sequelae (mental disease, hypertension, deformity or loss of function of limbs or organs) and their implications for health services as well as the victim's and society's psycho-social and economic circumstances.

In conclusion, "...bearing witness, having first-hand knowledge of humanitarian and human rights principles and their limitations, and by systematically collecting evidence of abuse, can be instrumental in tackling forces that constrain the realisation of human health and dignity" (Orbinski et al, 2007, p. 6).

Appendices

Appendix I IPID Complaint Form

Appendix II Istanbul Protocol Guidelines

Appendix III J88

Appendix IV GW 17/5

APPENDIX I

FORM 2

COMPLAINT REPORTING FORM BY MEMBER OF PUBLIC
(Regulation 2(4))

Complaint Details			
CAS/CR No/ Inquest No		Province	
Date of Incident		Time of Incident	
Reported to SAPS?	[ ] Yes [ ] No	Date Reported to SAPS	
Name of SAPS station			
Protection Order issued?	[ ] Yes [ ] No	Protection Order type	Interim [ ] Final [ ]
Date issued			

Incident relates to :
[ ] Death in police custody
[ ] Death as a result of police action
[ ] Discharge of firearm by police officer
[ ] Rape by police officer
On Duty [ ] Off Duty [ ]
[ ] Rape of person in police custody
[ ] Torture/assault by police officer
[ ] Corruption within the police

Complaint description (use additional folios if necessary):

Complainant Details (includes third party complaints)			
Role in the case	[ ] Complainant [ ] Third Party		
ID Number		Passport Number	
Title		First Name	
Middle Name		Surname	
Landline		Mobile	
Fax		Email	
Nationality		Gender	[ ] Male [ ]Female
Disabled status			
Address			
Country		City	
Suburb		Postal Code	
Preferred contact Method (E.g. E-mail, SMS, Post)			

Victim Details			
Passport Number			
First Name		Middle Name	
Surname			
Gender	[ ] Male [ ] Female	Race	
Age			

Service Member's Details			
Identified	[ ] Yes [ ] No	Rank	
Persal Number		ID Number	
Initials			
First Name		Middle Name	
Surname			
Gender	[ ] Male [ ] Female	Race	
Duty Station		Duty Station Unit	
Identified	[ ] Yes [ ] No	Rank	
Persal Number		ID Number	
Initials			
First Name		Middle Name	
Surname			
Gender	[ ] Male [ ] Female	Race	
Duty Station		Duty Station Unit	
Identified	[ ] Yes [ ] No	Rank	
Persal Number		ID Number	

Initials			
First Name		Middle Name	
Surname			
Gender	[ ] Male [ ] Female	Race	
Duty Station		Duty Station Unit	
Contact Number			
On Duty	[ ] Yes [ ] No		
Vehicle Registration Number			
Details of Witnesses to Incident			
Title		First Name	
Middle Name		Surname	
Landline		Mobile	
Title		First Name	
Middle Name		Last Name	
Landline		Mobile	
Title		First Name	
Middle Name		Surname	
Landline		Mobile	
Title		First Name	
Middle Name		Suname	
Landline		Mobile	

COMPLAINANT'S FULL NAMES:

COMPLAINANT'S SIGNATURE:

DATE:

APPENDIX II

ANNEX IV

Guidelines for the medical evaluation of torture and ill-treatment

The following guidelines are based on the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.* These guidelines are not intended to be a fixed prescription, but should be applied taking into account the purpose of the evaluation and after an assessment of available resources. Evaluation of physical and psychological evidence of torture and ill-treatment may be conducted by one or more clinicians, depending on their qualifications.

I. Case information

Date of exam: ..... Exam requested by (name/position): .....

Case or report No.: ..... Duration of evaluation: ..... hours, ... minutes

Subject's given name: ..... Birth date: ..... Birth place: .....

Subject's family name: ..... Gender: male/female: .....

Reason for exam: ..... Subject's ID No.: .....

Clinician's name: ..... Interpreter (yes/no), name: .....

Informed consent: yes/no If no informed consent, why?: .....

Subject accompanied by (name/position): .....

Persons present during exam (name/position): .....

Subject restrained during exam: yes/no; If "yes", how/why? .....

Medical report transferred to (name/position/ID No.): .....

Transfer date: ..... Transfer time: .....

Medical evaluation/investigation conducted without restriction (for subjects in custody): yes/no

Provide details of any restrictions: .....

II. Clinician's qualifications (for judicial testimony)

Medical education and clinical training

Psychological/psychiatric training

Experience in documenting evidence of torture and ill-treatment

Regional human rights expertise relevant to the investigation

Relevant publications, presentations and training courses

Curriculum vitae.

III. Statement regarding veracity of testimony (for judicial testimony)

For example: "I personally know the facts stated below, except those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background information

General information (age, occupation, education, family composition, etc.)

Past medical history

Review of prior medical evaluations of torture and ill-treatment

Psychosocial history pre-arrest.

V. Allegations of torture and ill-treatment

1. Summary of detention and abuse
2. Circumstances of arrest and detention
3. Initial and subsequent places of detention (chronology, transportation and detention conditions)
4. Narrative account of ill-treatment or torture (in each place of detention)
5. Review of torture methods.

VI. Physical symptoms and disabilities

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute symptoms and disabilities
2. Chronic symptoms and disabilities.

VII. Physical examination

1. General appearance
2. Skin
3. Face and head
4. Eyes, ears, nose and throat
5. Oral cavity and teeth
6. Chest and abdomen (including vital signs)
7. Genito-urinary system
8. Musculoskeletal system
9. Central and peripheral nervous system.

VIII. Psychological history/examination

1. Methods of assessment
2. Current psychological complaints
3. Post-torture history
4. Pre-torture history
5. Past psychological/psychiatric history
6. Substance use and abuse history
7. Mental status examination
8. Assessment of social functioning
9. Psychological testing: (see chapter VI, sect. C.1, for indications and limitations)
10. Neuropsychological testing (see chapter VI, sect. C.4, for indications and limitations).

IX. Photographs

X. Diagnostic test results (see annex II for indications and limitations)

XI. Consultations

XII. Interpretation of findings

1. Physical evidence
   A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
   B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)
   C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.
2. Psychological evidence
   A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.
   B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.
   C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual?
   D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
   E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

XIII. Conclusions and recommendations

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.
2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and care for the individual.

XIV. Statement of truthfulness (for judicial testimony)

For example: "I declare under penalty of perjury, pursuant to the laws of ..... (country), that the foregoing is true and correct and that this affidavit was executed on ..... (date) at ..... (city), ... (State or province)."

XV. Statement of restrictions on the medical evaluation/investigation (for subjects in custody)

For example: "The undersigned clinicians personally certify that they were allowed to work freely and independently and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities"; or "The undersigned clinician(s) had to carry out his/her/their evaluation with the following restrictions: ....."

XVI. Clinician's signature, date, place

XVII. Relevant annexes

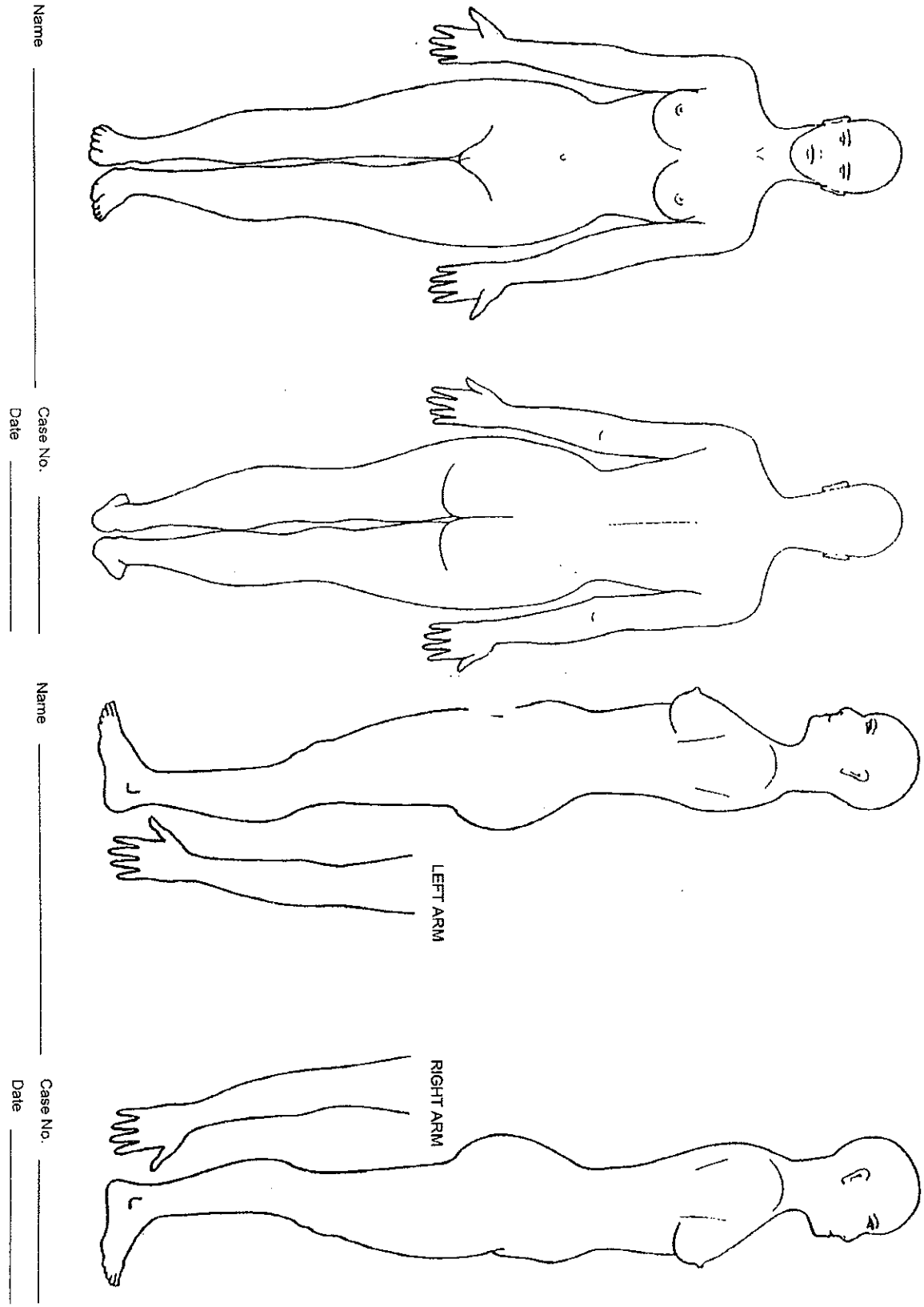
A copy of the clinician's curriculum vitae, anatomical drawings for identification of torture and ill-treatment, photographs, consultations and diagnostic test results, among others.

Further information can be obtained from: The Office of the United Nations High Commissioner for Human Rights, Palais des Nations, 1211 Geneva 10, Switzerland

Tel: (+41-22) 917 91 59
E-mail: infodesk@ohchr.org *Internet*: www.ohchr.org

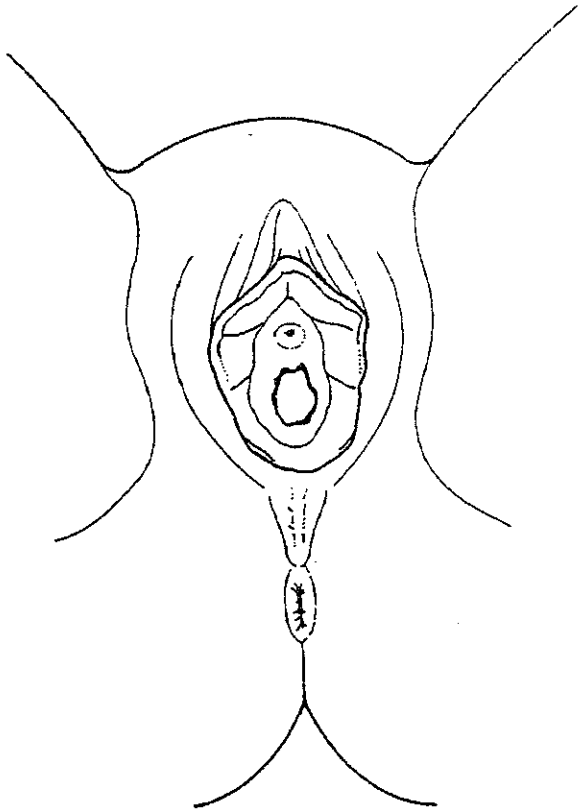
ANNEX III

Anatomical drawings for documentation of torture and ill-treatment



95

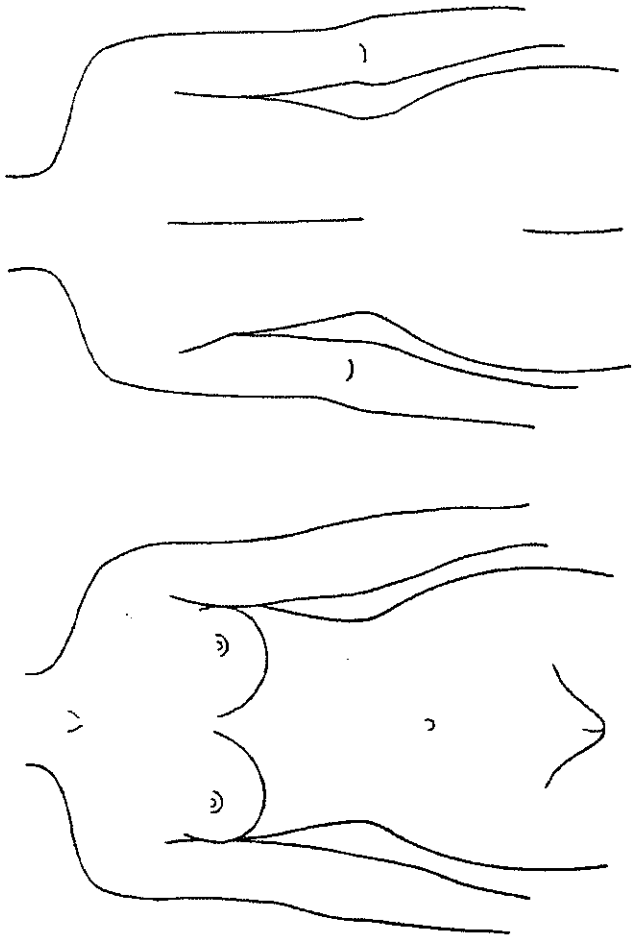
PERINEUM—FEMALE



Name _____ Case No. _____

Date _____

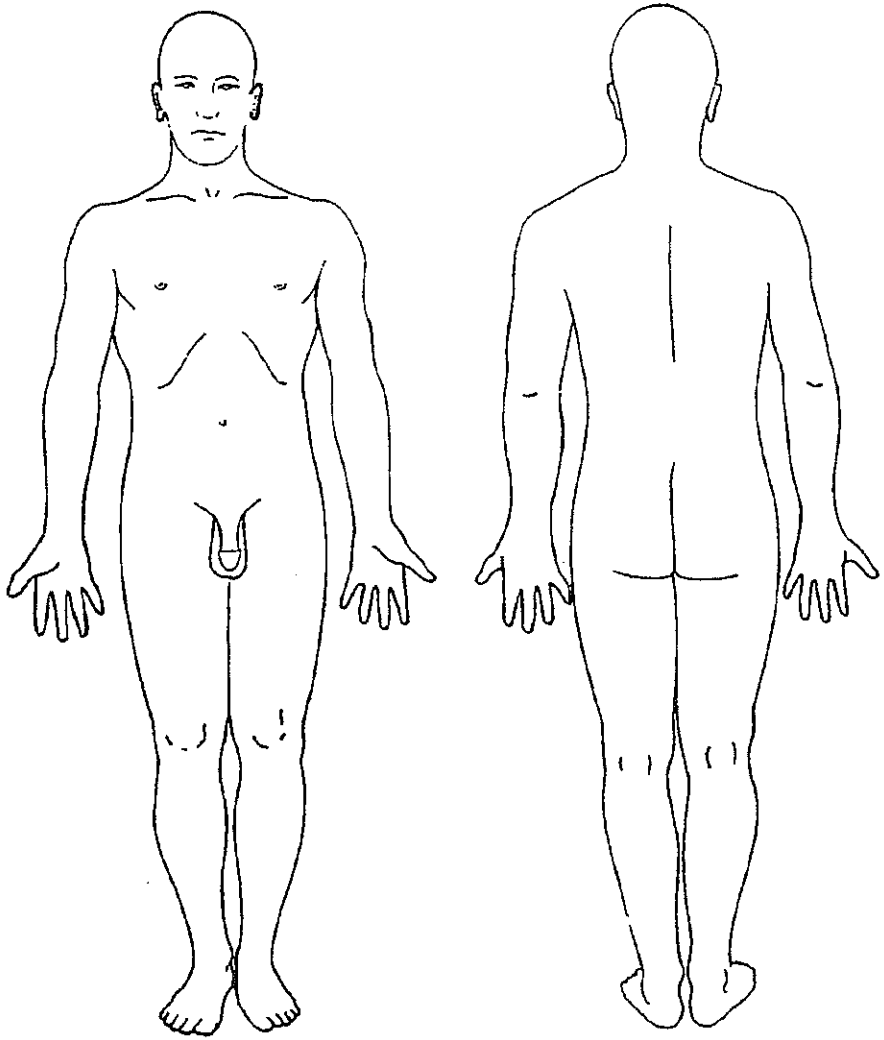
THORACIC ABDOMINAL, FEMALE—ANTERIOR AND POSTERIOR VIEWS



Name _____ Case No. _____

Date _____

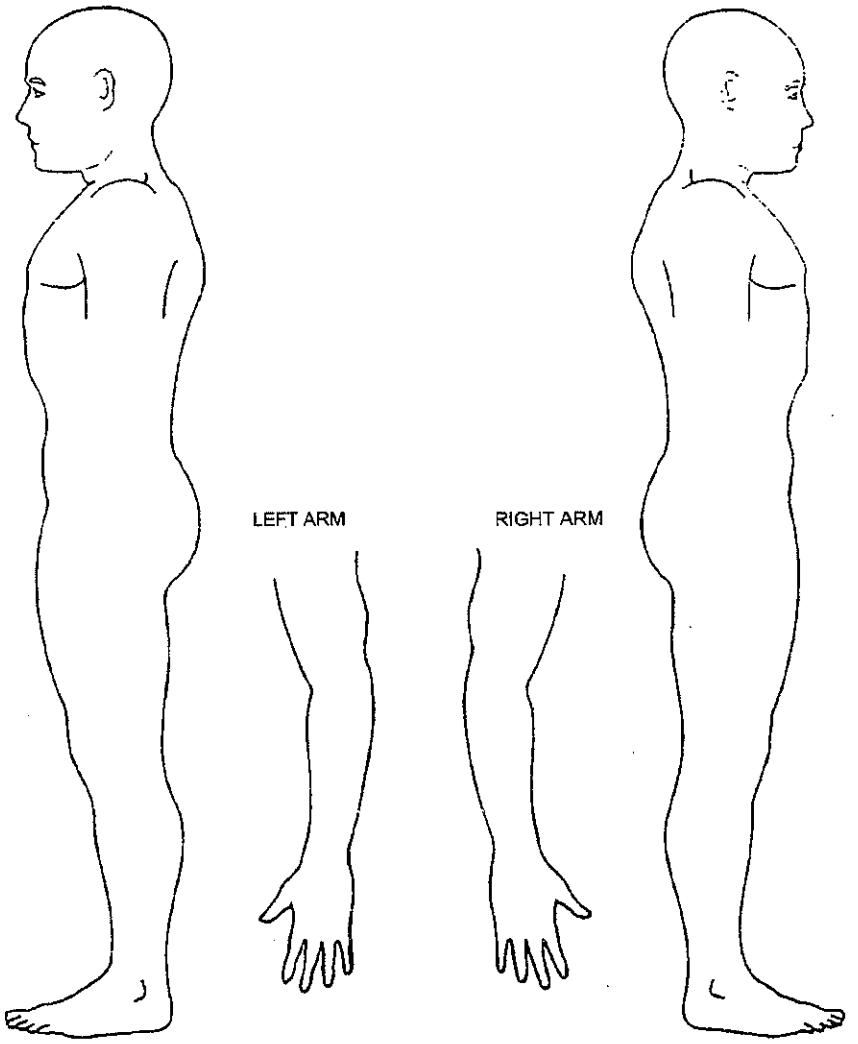
FULL BODY, MALE—ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)



Name _____ Case No. _____

Date _____

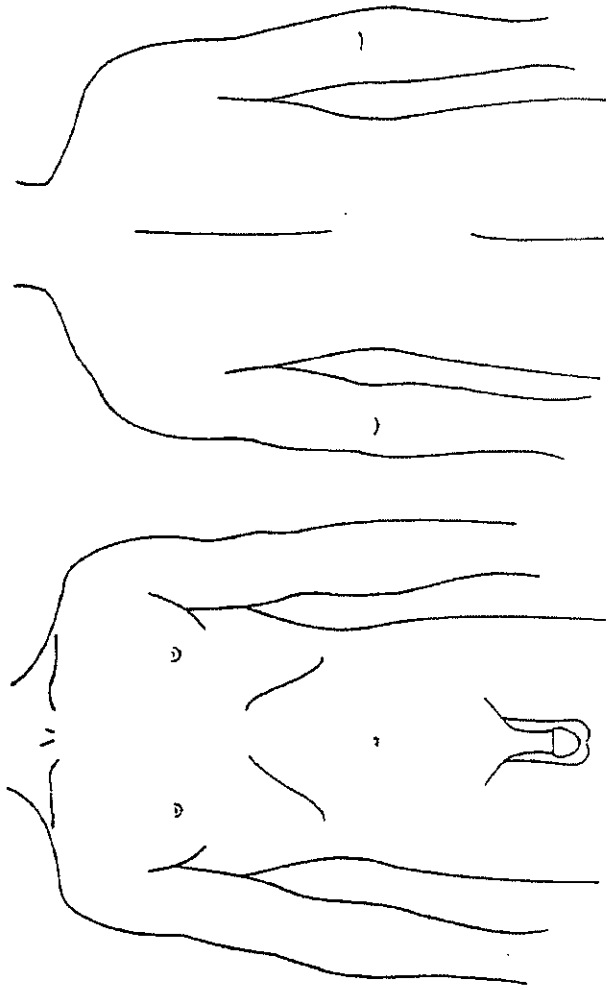
FULL BODY, MALE—LATERAL VIEW



Name _____ Case No. _____

Date _____

THORACIC ABDOMINAL, MALE—ANTERIOR AND POSTERIOR VIEWS



Name _____ Case No. _____

Date _____

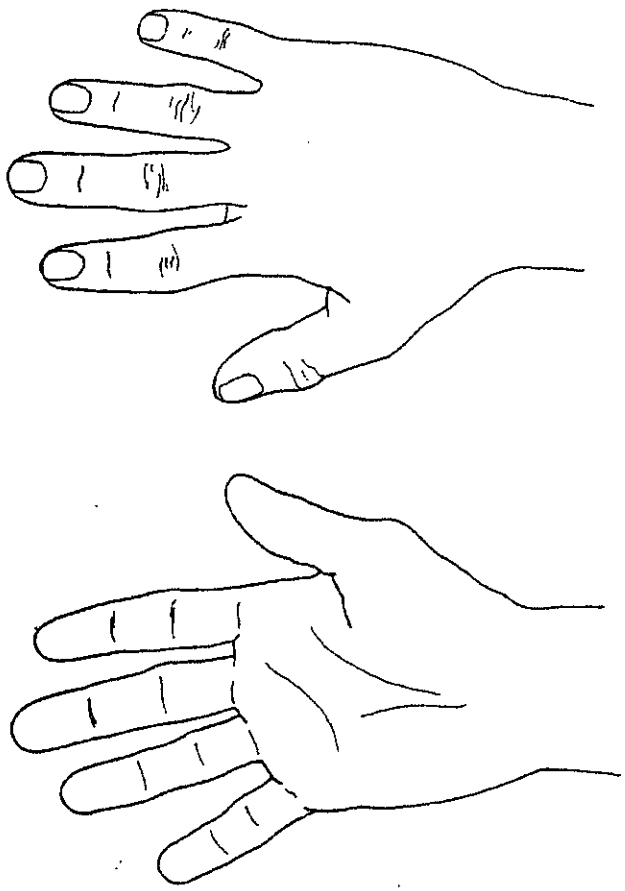
FEET—LEFT AND RIGHT PLANTAR SURFACES



Name _____ Case No. _____

Date _____

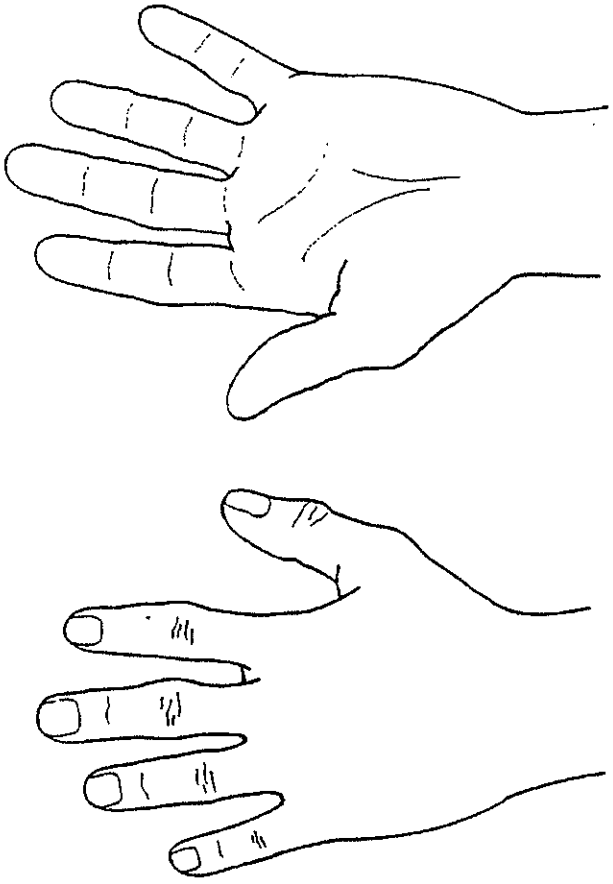
RIGHT HAND—PALMAR AND DORSAL



Name _____ Case No. _____

Date _____

LEFT HAND—PALMAR AND DORSAL



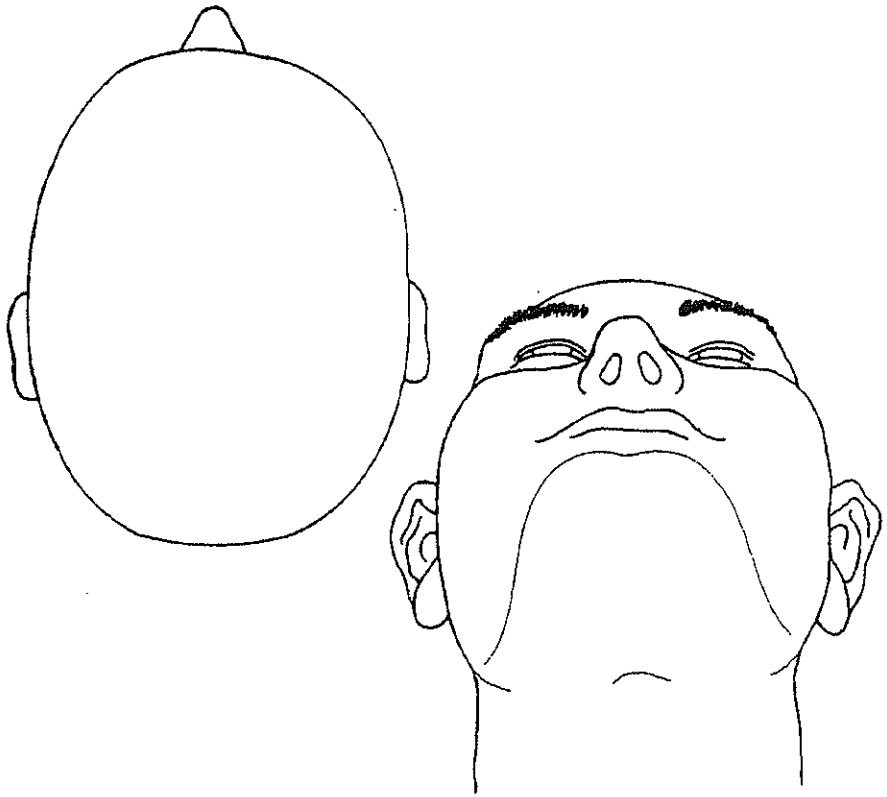
Name _____ Case No. _____

Date _____

99

69

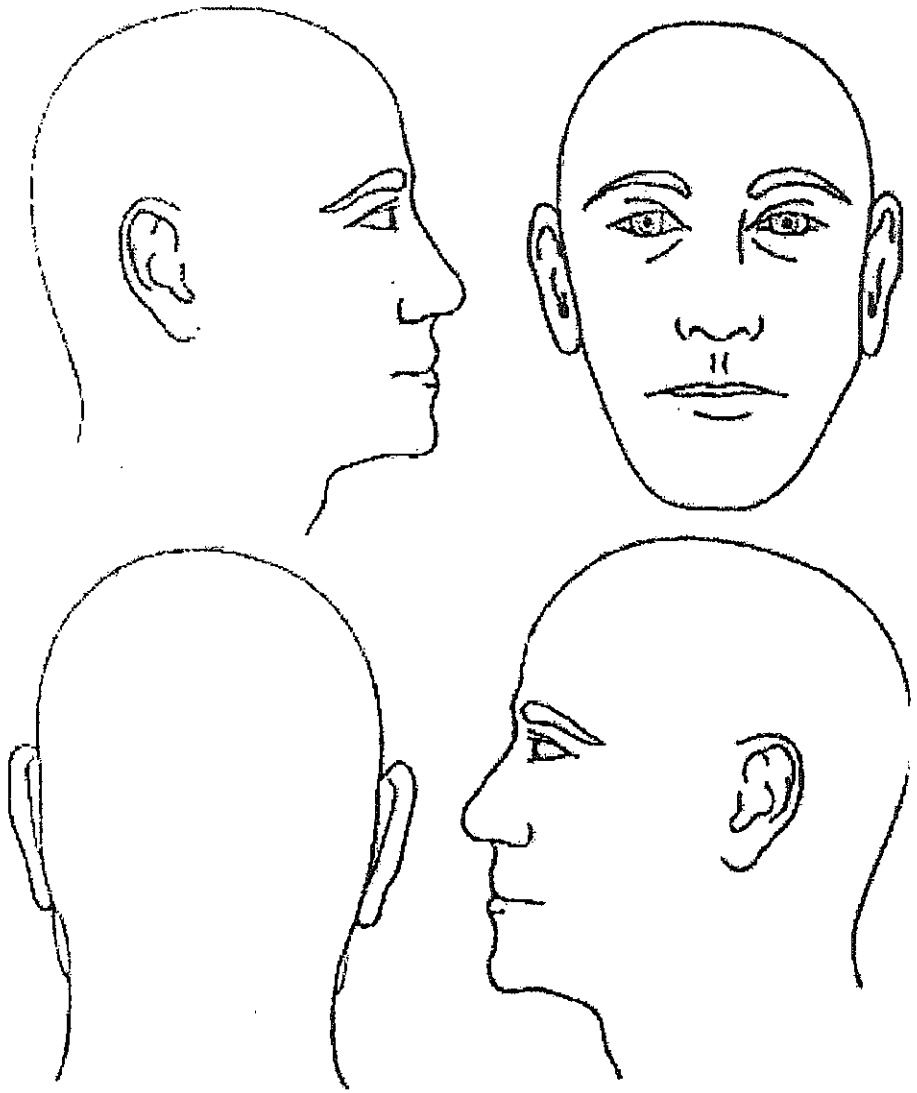
HEAD—SURFACE AND SKELETAL ANATOMY, SUPERIOR VIEW—INFERIOR VIEW OF NECK



Name _____ Case No. _____

Date _____

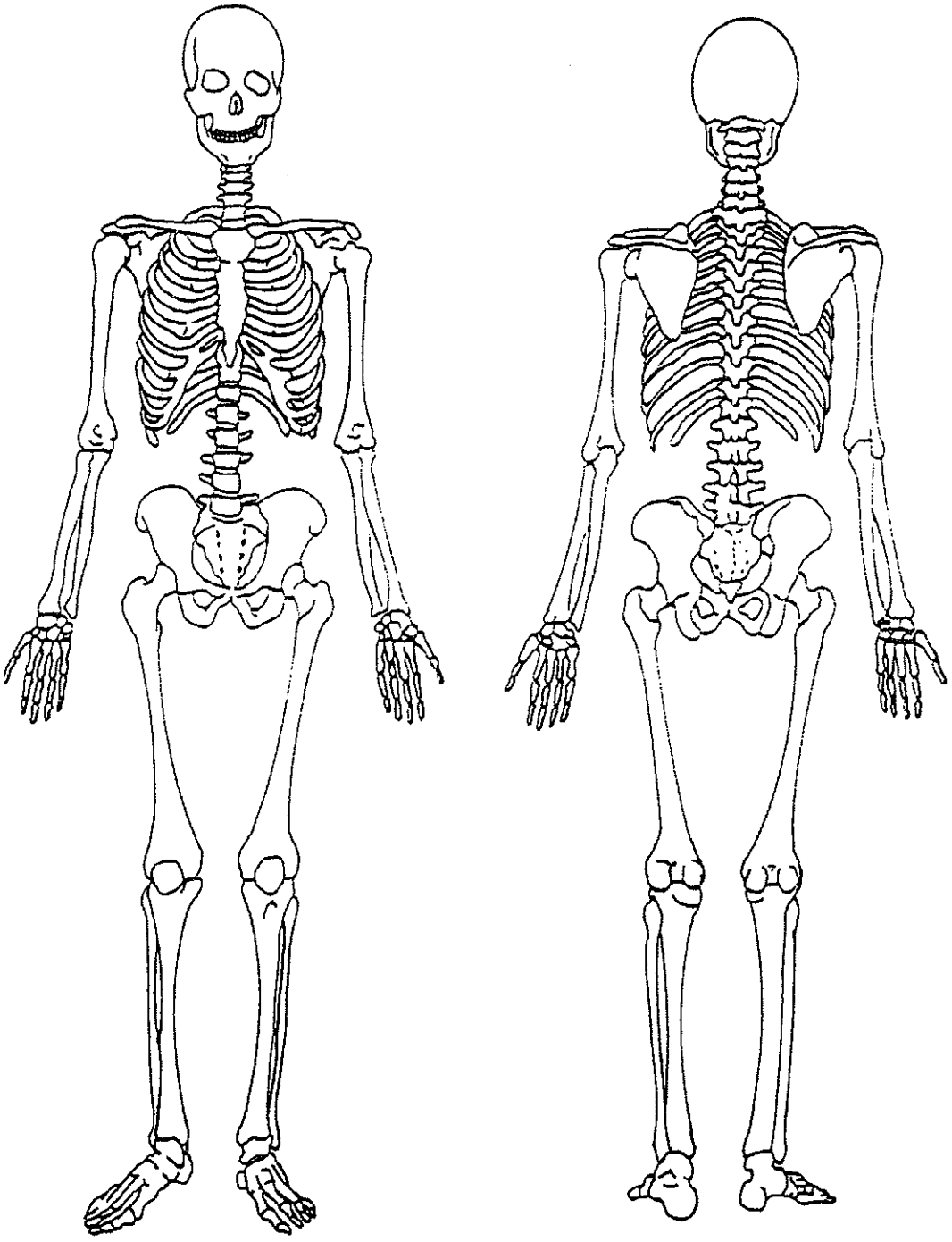
HEAD—SURFACE AND SKELETAL ANATOMY, LATERAL VIEW



Name _____ Case No. _____

Date _____

SKELETON—ANTERIOR AND POSTERIOR VIEWS



Name _____ Case No. _____

Date _____

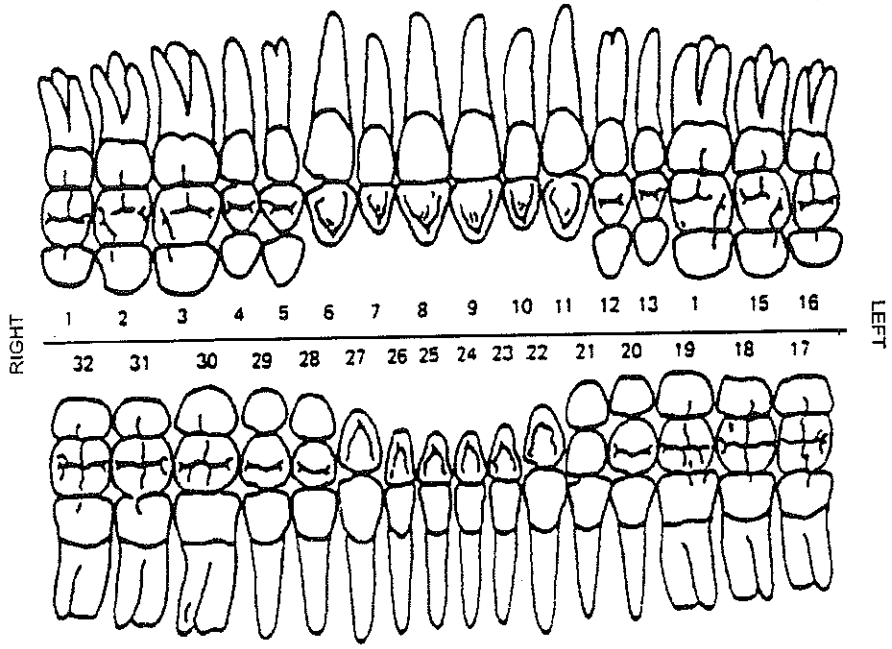
101

MARK ALL EXISTING RESTORATIONS AND MISSING TEETH ON THIS CHART

Estimated Age _____

Sex _____

Race _____



Circle descriptive term

Prosthetic appliances present

Maxilla

Full denture

Partial denture

Fixed bridge

Mandible

Full denture

Partial denture

Fixed bridge

Describe completely all prosthetic appliances or fixed bridges _____

_____

_____

_____

_____

Stains on teeth

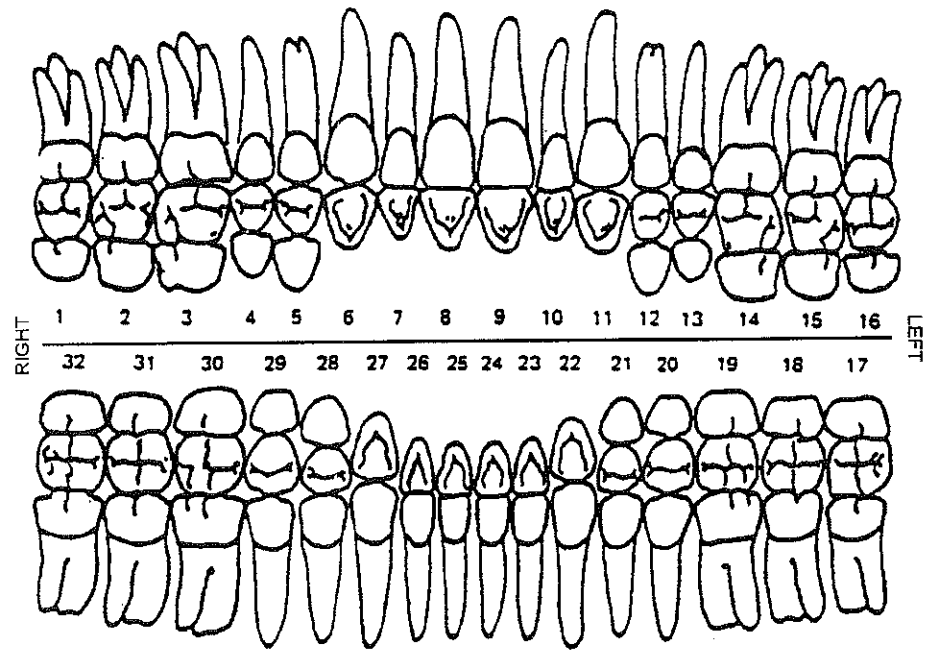
Slight

Moderate

Severe

MARK ALL CARIES ON THIS CHART

Outline all caries and "X" out all missing teeth



Circle descriptive term

Relationship

Normal

Undershot

Overbite

Periodontal Condition

Excellent

Average

Poor

Calculus

Slight

Moderate

Severe

102

APPENDIX III

G.P.S. 01/02

J88 (81/805259)

REPUBLIC OF SOUTH AFRICA

REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE COMPLETION OF A MEDICO-LEGAL EXAMINATION

To be completed in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Police station:	2. CAS No.:	3. Investigating officer: Name and number:	4. Tme ☐☐:☐☐ Day ☐☐ Month ☐☐ Year ☐☐☐☐

5. Name (Capacity) e.g. Nurse, Doctor, etc

6. Registered qualifications:

7. Phone number:

8. Fax number:

9. Place of examination:

10. Physical practice address or stamp:

11. Full names of person examined: 12. Gender: M ☐ F ☐ 13. Date of birth/apparent age:

B. GENERAL HISTORY

1. Relevant medical history and medication:

C. GENERAL EXAMINATION

1. Condition of clothing:

2. Height (cm):	3. Mass:	4. General body build:

5. Clinical findings: In every case the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of all injuries and wounds must also be noted on the sketches.

6. Mental health and emotional status:

7. Clinical evidence of drugs or alcohol:

8. CONCLUSIONS

Signature (Capacity e.g. Nurse)

DEPARTMENT OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT

D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE

2

1. Age of menarche ☐☐	2. Number of pregnancies ☐☐	3. Number of deliveries ☐☐	4. Duration of pregnancy (if applicable) ☐☐ weeks
5. Contraception (indicate with X): Yes ☐ No ☐		7. First date of last menstruation:	
6. Method and last date of application/ingestion:		8. Duration of period	9. Duration of cycle
10. Date and time of last intercourse with consent:	11. Number of consensual sexual partners during last 7 days:		12. Condoms: Yes ☐ No ☐
13. Since the alleged offence took place, has the person (indicate with X)	bathed ☐	washed ☐	douched ☐ showered ☐ urinated ☐ changed clothing ☐

E. GYNAECOLOGICAL EXAMINATION (State clinical findings)

1. Breast development: Tanner stage 1-5 ☐	2. Pubic hair: Tanner stage 1-5 ☐	3. Mons pubis:
4. Clitoris		5. Frenulum of clitoris:
6. Urethral orifice:		7. Para-urethral folds:
3. Labia majora:		9. Labia minora:
10. Posterior fourchette: scarring:		bleeding:
tears:		increased friability:
11. Fossa navicularis:		
12. Hymen: configuration:	13. Opening diameter (mm): Transverse ☐☐	Vertical ☐☐
14 Swelling:	15. Bumps:	16. Clefts:
17. Fresh tears (position):	18. Synechiae:	19. Bruising:
20. Vagina: Number of fingers admitted:	bleeding:	tears:
	discharge:	
21. Cervix:	erosion:	discharge:
	bleeding:	other:
22. Perineum:		

F. SAMPLES TAKEN FOR INVESTIGATION

1. Forensic specimens taken: Urine sample for pregnancy test: Positive ☐ Negative ☐	Seal number of Evidence Collection Kit:
2. Specimens handed to: Name:	Rank and Force number:
Signature:	
3. CONCLUSIONS	
	Signature (Capacity e.g. Nurse)

G. ANAL EXAMINATION (State clinical findings) 3

SKIN SURROUNDING THE ORIFICE
1. Hygiene
2. Pigmentation:
3. Fissures/cracks:
4. Abrasions:
5. Scars:
6. Swelling/thickening:
7. Redness/erythema:
8. Bruising/haematoma:
9. Tags:

ORIFICE
10. Tears/fissures:
11. Swelling/thickening of rim (tyre sign):
12. Funneling:
13. Reflex dilatation:
14. Shortening/eversion of anal canal:
15. Cupping:
16. Twitchiness/winking:
17. Discharge:

DIGITAL EXAMINATION
18. Presence of hard faeces in rectum:
19. Laxity (pressure on anal orifice):
20. Thickening of anal verge:
21. Tone (sphincter grip):

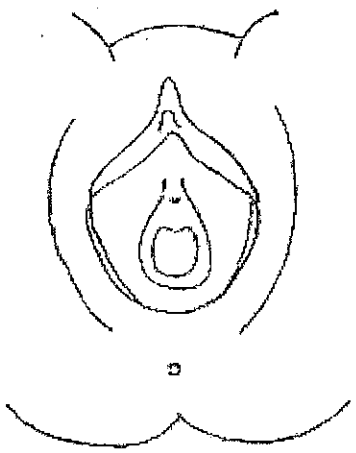
22. CONCLUSIONS

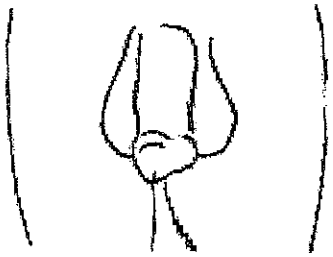
H. MALE GENITALIA

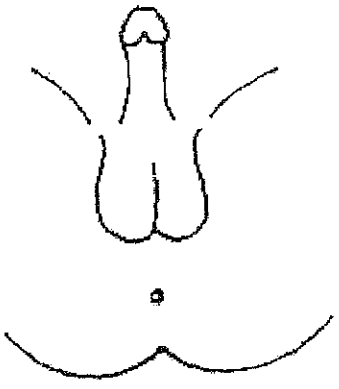
1. Genital development: Tanner stage 1-5 ☐
2. Glans:
3. Testes:
4. Ulceration:
5. Presence of faeces:
6 Pubic hair: Tanner stage 1-5: ☐
7. Shaft:
8. Epididymus:
9. Penile discharge:
10. Circumcision:
11. Prepuce and frenulurn:
12. Scrotum:
13. Vas deferens:
14. Smegma:
15. Urethral orifice:

16. CONCLUSIONS

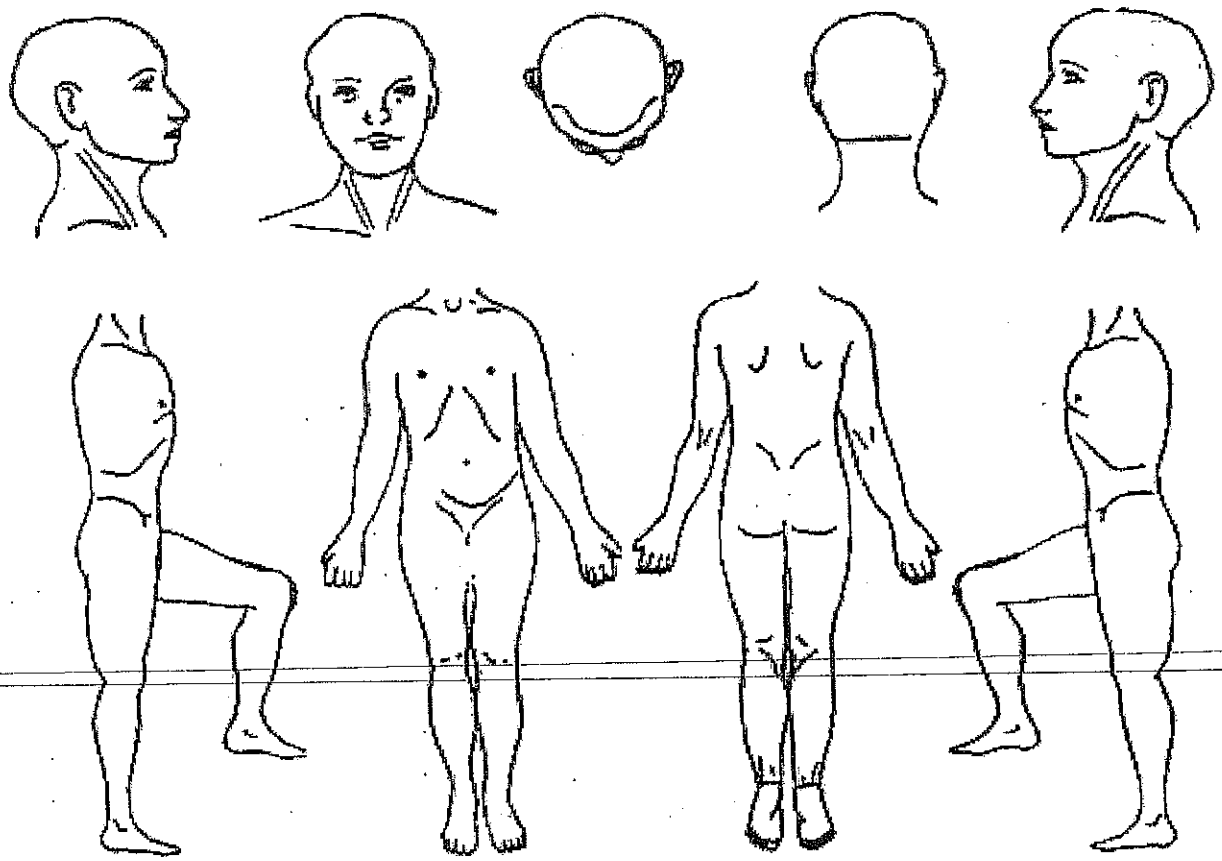
SCHEMATIC DRAWING OF FINDINGS

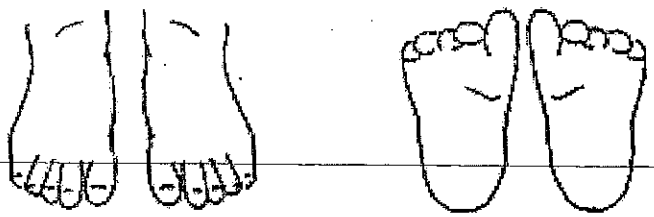


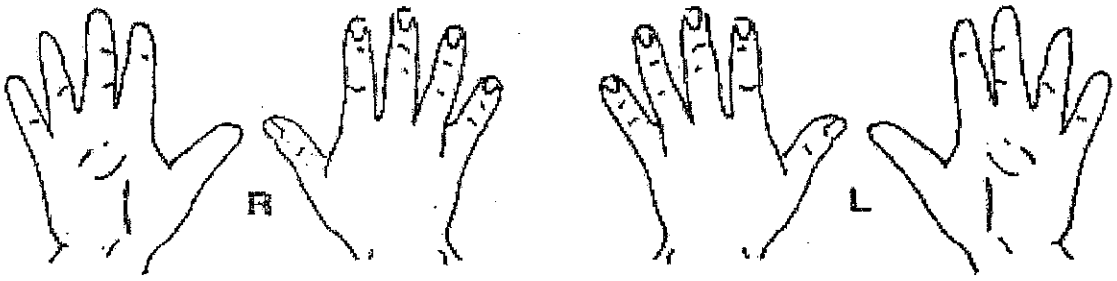


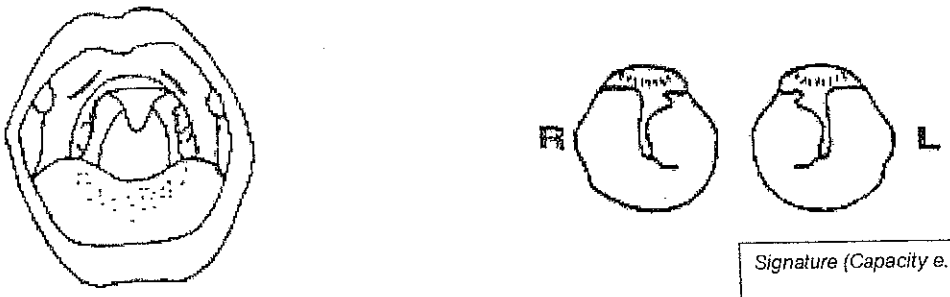


Signature (Capacity e.g. Nurse)









Signature (Capacity e.g. Nurse)

POLICE STATION: ..... CAS NO.: ..... / ..... / ..... INVESTIGATING OFFICER .....

***CERTIFICATE IN TERMS OF SECTION 212(4) AND 213(3) OF ACT 51 OF 1977 (AS AMENDED)

I, ... *(* Full names and Surname)*

hereby certify as follows:

I am in the service of the State / provincial administration / in the service of or attached to the South African Institute for Medical Research / a university in the Republic *(*Delete which is not applicable)* in my capacity as a *District Surgeon / Registered Medical Practitioner / Doctor / Nurse / Other *(Please specify)* .....
(Delete which is not applicable)*

On the ..... day of ..... year ..... at *..... H..... *(*Time of examination)*
and at ..... *(*State place where examination took place)*,
I examined ..... *(*State full names of person examined)*.

I recorded my findings and observations on the preceding pages 1 to 4 of this **J88** form.

The facts recorded on pages 1 to 4 of the **J88** form were established by an examination requiring skill in anatomy.

The contents of this **J88** form is true to the best of my knowledge and belief and I am making this statement knowing that, if it were tendered in evidence, I would be liable to prosecution if I willfully stated in it anything I knew to be false or which I do not believe to be true.

DATED AT ..... *(*PLACE)* ON THE ..... DAY OF
..... year ..... AT *..... H ..... *(*TIME)*.

.....
SIGNATURE OF DECLARENT

.....
PRINT NAME AND SURNAME

*** *(NB: Section 212(4)(a)(i) to (v;) of Act 51 of 1977:*
" Whenever any fact established by any examination or process requiring any skill-
.... in ,anatomy...a (n) affidavit made ... shall, upon its mere production ... be prima facie proof of such fact: Provided that the person who may make such affidavit may, in any case in which skill is required in ..., anatomy ..., issue a certificate in lieu of such affidavit...")

J88

ADMISSIBILITY BY CONSENT I.T.O. SEC 21 3(3) READ WITH SEC 213(2)(a) OF THE CPA

"I .....DECLARE THAT I HAVE CONDUCTED THE ABOVE-MENTIONED EXAMINATION REFERED TO IN THE J88, ON ..... (Name of patient), IN PERSON ON .....(Date) AND THAT THE CONTENTS OF THIS FORM (J88) IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND THAT I AM MAKING THIS STATEMENT KNOWING THAT, IF IT WERE TENDERED IN EVIDENCE, I WOULD BE LIABLE TO PROSECUTION IF I WILFULLY STATED IN IT ANYTHING I KNEW TO BE FALSE OR WHICH I DO NOT BELIEVE TO BE TRUE.

SIGNED: .....

PRINT NAME AND SURNAME: .....

DATE: .....

APPENDIX IV

Notification of medical condition

(Sections 32, 47(i)(a) and 47(i)(b) of Act 63 1977)

Department of National Health and Population Development

Aanmelding van mediese toestand

(Artikels 32, 47(i)(a) en 47(i)(b) van Wet 63 van 1977)

Departement van Nasionale Gesondheid en Bevolkingsontwikkeling

Please print • Where appropriate, mark the correct box with a tick (✓) • Complete in duplicate. Original to be sent to local authority where patient was diagnosed: copy to remain in book.

Gebruik asseblief drukskrif • Waar toepaslik, merk die korrekte blok (✓) • Voltooi in duplikaat. Die oorspronklike word gestuur aan die plaaslike owerheid waar die pasiënt gediagnoseer is: die afskrif bly in die boek.

WET GLUE AND SEAL BY FOLDING

AS INDICATED

DETAILS OF PATIENT / BESONDERHEDE VAN PASIËNT

Surname / Van	First names / Voorname

Age / Ouderdom	Sex	Ethnic group / Etniese groep
	Male ☐ Manlik Female ☐ Vroulik	Asian ☐ Asiër Coloured ☐ Kleurling Black ☐ Swart White ☐ Blank

Residential address / Woonadres

If resident on a farm, state farmer's name as well as name and number of farm. In other rural areas, give name of chief, induna, village, nearest hill or river, nearest school or clinic

Indien woonagtig op 'n plaas, noem die boer se naam sowel as die naam en nommer van die plaas. In ander landelike gebiede, gee die naam van die stamkaptein, induna, dorp, naaste heuwel of rivier, naaste skool of kliniek

District / Distrik

Tel. no. / Tel. nr.

Name and address of employer, school, creche or other institution where patient spends much of the day

Naam en adres van werkgewer, skool, creche of ander instelling waar die pasiënt 'n groot gedeelte van die dag is

Tel. no. / Tel. nr.

FOLD NOW

FOLD NOW

DETAILS OF MEDICAL CONDITION / BESONDERHEDE VAN MEDIESE TOESTAND

Medical condition / Mediese toestand	
Date of onset / Aanvangsdatum	Date of death (if applicable) / Sterftedatum (indien van toepassing)
Possible place of infection / Moontlike plek van infeksie	
Diagnosis was based on / Diagnose is gebaseer op	Clinical history and examination only ☐ Net kliniese geskiedenis en ondersoek Clinical and other investigations ☐ Kliniese en ander ondersoeke

RESULTS OF INVESTIGATIONS / ONDERSOEKRESULTATE

Investigation (excluding TB sputum) ↓ / Ondersoek (TB sputum uitgesluit)	Results ↓ / Resultate
	Awaiting result ☐ Wag vir resultaat
	Awaiting result ☐ Wag vir resultaat
	Awaiting result ☐ Wag vir resultaat

If TB, give sputum result →	Microscopy / Mikroskopie	Culture / Kultuur	← Indien TB, gee sputum resultaat
	Positive ☐ Positief Negative ☐ Negatief Awaiting results ☐ Wag vir resultaat	Positive ☐ Positief Negative ☐ Negatief Awaiting results ☐ Wag vir resultaat	

FOLD NOW →

FOLDNOU →

REFERRED TO / VERWYS NA

Name of hospital or clinic / Naam van hospitaal of kliniek	
Patient Registration No: / Pasiënt registrasie nr:	Date of admission / Datum van opname

NOTIFIED BY / AANGEMELD DEUR

Name	
Address / Adres	Profession / Beroep: Medical practitioner ☐ Geneesheer; Nurse ☐ Verpleegster; Other ☐ Ander
Tel. no. / Tel. nr.	Signature / Handtekening
	Date / Datum

MAAK GOM NAT EN VERSEEL DEUR TE

VOU SOOS AANGEDUI

Local authority: If a copy of this notification is to be sent to another local authority, please confirm whether you will include this notification in your weekly summaries (GW 17/3 or 17/4)

Yes ☐ Ja
No ☐ Nee

Plaaslike overheid: Indien 'n afskrif van hierdie aanmelding aan 'n ander plaaslike owerheid gestuur word, bevestig asseblief of hierdie aanmelding by weeklikse opsomming (GW 17/3 of 17/4) ingesluit gaan word

REPLY BY LOCAL AUTHORITY / ANTWOORD DEUR PLAASLIKE OWERHEID

Reply to referring doctor/nurse with brief report of further findings and management

Antwoord aan verwysende dokter/verpleegster oor verdere bevindinge en hantering

Signature / Handtekening	Date / Datum	Tel. no. / Tel. Nr.

FOLD NOW

FOLDNOU

GW 17/5

G.P.-S. 004-0293

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING
DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

GW 17/3

WEEKLIKSE OPGAWE VAN ALLE AANMELDBARE MEDIESE TOESTANDE • WEEKLY RETURN OF ALL NOTIFIABLE MEDICAL CONDITIONS

(Artikel 28 van Wet 63 van 1977/Section 28 of Act 63 of 1977)

Instruksies/Instructions

1. Moet in duplikaat voltooi word.
   To be completed in duplicate.
2. Sterfgevalle weens aansteeklike siektes moet op vorm GW 17/4 ingevul word.
   Deaths from infectious diseases should be filled in on form GW 17/4.

AAN DIE STREEKDIREKTEUR VAN GESONDHEIDSDIENSTE
TO THE REGIONAL DIRECTOR OF HEALTH SERVICES

Naam van Plaaslike Bestuur
Name of Local Authority.....

Aanmeldbare mediese toestande aangemeld gedurende die week geëindig Saterdag
Notifiable medical conditions notified during the week ended Saturday.....19.....

Naam van persoon Name of person	Ouderdom Age	Geslag Sex	Bevolkingsgroep Population group	Adres waar die pasiënt siek geword het Address where the patient sickened	Siekte Disease	Datum waarop siekte ingetree het Onset date	Datum van aangifte Notified date	Waarskynlike plek, datum en bron van besmetting Probable place, date and source of infection Ander gevalle op dieselfde perseel Any other cases on same premises	Volledige besonderhede van stappe deur Plaaslike Bestuur gedoen Full details of action taken by Local Authority

.....
Handtekening van Stadsklerk of Sekretaris
Signature of Town Clerk or Secretary

Datum
Date.....

Plek
Place.....

011

DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGSONTWIKKELING
DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

GW 17/4

Opgawe van gevalle van dood weens aangeebare siektes wat by die..... van .....aangegee is gedurende die week geëindig Vrydag,.....
(Naam van plaaslike bestuur)

Return of deaths from notifiable diseases reported to the..... of .....during the week ended Friday, ...
(Name of local authority)

Naam van oorledene Name of deceased	Ouderdom Age	Geslag Sex	(1) Bevolkings-groep (1) Population group	Woonadres Residential address	Siekte wat die dood veroorsaak het Disease causing death	Duur van siekte Duration of illness	Datum van dood Date of death

(1) Gebruik die volgende afkortings om die bevolkingsgroep aan te dui: W vir Blankes; K vir Kleurlinge of persone van gemengde bevolkingsgroep; S vir Swartes; A vir Indiërs of ander Asiate.
(1) Use the following abbreviations to denote the population group: W for White; C for Coloured or persons of mixed population group; B for Blacks; A for Indians or other Asians.

L.W.—Hierdie vorm moet ingevul en aan die Streekdirekteur van Gesondheidsdienste gestuur word, voor of op die Maandag wat volg op die week waarop dit betrekking het.
N.B.—This form should be filled in and dispatched to the Regional Director of Health Services not later than the Monday following the week to which it refers.

Plek
Place.....

Datum
Date.....

(Geteken)
(Signed).....
Stadsklerk, Sekretaris of Landdros
Town Clerk, Secretary or Magistrate

G.P.-S. 004-0294

University
of the Witwatersrand,
Johannesburg

Human Research Ethics Committee (Medical)
(formerly Committee for Research on Human Subjects (Medical)

Secretariat: Research Office, Room SH10005, 10th floor, Senate House • Telephone: +27 11 717-1234 • Fax: +27 11 339-5708
Private Bag 3, Wits 2050, South Africa

Ref: W-CJ-130909-1

09/09/2013

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator: **Mrs T Jacovides (student no 0615403N).**

Project title: **The legal and ethical duty of the medical doctor in reporting police brutality.**

Reason: This is a analysis of information in the public domain. There are no human participants.

UNIVERSITY OF THE WITWATERSRAND
PROF PE CLEATON-JONES
HREC (MEDICAL)
2013 -09- 09
JOHANNESBURG

Professor Peter Cleaton-Jones
Chair: Human Research Ethics Committee (Medical)

copy: Anisa Keshav, Zanele Ndlovu, Wits Research Office

REFERENCES

Amnesty International 2013, '*Annual Report, 2013, South Africa.*' http:www.amnesty.org/en/for_media/ (accessed January 28, 2014).

Amnesty International. 1 March 2013. 'Brutal reign by South African police claims another victim.' http://www.amnesty.org/en/for-media/ (accessed November 28, 2013).

Audet, Anne-Marie 1995. 'The Role of the Physician And Medical Professional in the Prevention of International Torture and in the Treatment of Survivors.' *American College of Physicians,*vol. 122, pp. 607-613.

Baldwin-Ragaven, Laurel, de Gruchy Jeanelle, and Leslie London 1999. *An Ambulance of the Wrong Colour: Health Professionals,Human Rights and Ethics in South Africa.* University of Cape Town Press, Rondebosch.

Baxter, L.G 1985, 'Doctors on Trial: Steve Biko, Medical Ethics and the Courts' scholarship.law.duke.edu/cgi/viewcontent.cgi?article=2678&contextfaculty_scholarship (Accessed 25 May 2013)

Bell, Sonya 2006. 'The Politician,the Economist, and the Medical Professional: the Unholy Trinity of Apartheid in South Africa.' *Undercurrent* III (1), pp. 65-72.

Bruce, David 2002. *Police Brutality in South Africa.* Inter-African Network for Human Rights and Development (Afronet), 2002.

Bruce, David, Kate Savage, and Johan de Waal 2000. 'A Duty to Answer Questions? The Police, the Independent Complaints Directorate and the Right to Remain Silent.' *South African Journal on Human Rights.* Vol.16, Part1.

Burger, Johan. 'Understanding police brutality in South Africa: challenges and solution.' *Institute for Security Studies Africa.* 11 April 2013. www.issafrica.org/events/understanding-police-brutality-in-south-africa-challenges-and-solutions (accessed April 30, 2013).

Cawthra, Gavin 1992, *South Africa's Police. From police state to democratic policing?* Catholic Institute for International Relations, Russel Press, London.

Chapman, Audrey R, and Leonard S. Rubenstein 1998, 'Human Rights and Health:The Legacy of Apartheid: Underlying Causes of Human Rights Violations in the Health Sector.' *American Academy for the Advancement of Science.* shr.aaas.org/loa/under.htm (accessed June 05, 2013).

Coleman, Max (ed) 1998, *A Crime Against Humanity.* Human Rights Committee of South Africa.

de Vos, Pierre 2013, *Constitutionally Speaking. Outcry about police brutality sheer hypocrisy.* 1 March 2013. constitutionallyspeaking.co.za/outcry-about-police-brutality-sheer-hypocrisy (accessed May 6, 2013).

Dissel, A Roberts, S & Jensen,A 2009, *Torture in South Africa: Exploring torture and cruel, inhumane and degrading treatment through media.* Centre for the Study of Violence and Reconciliation, Johannesburg

English, Veronica, Gillian Romro-Critchley, and Ann Somerville 2000, "Ethics briefings." *Journal of Medical Ethics,*26,(4), pp. 286-287.

Faull, Andrew, and Brian Rose 2012, "Professionalism and the South African Police Service." *Institute for Security Studies,* Paper 240, October, pp.1-16.

Gillon, Ranaan 1986, Acts and omissions, killing and let die. *British Medical Journal, 292,* pp. 126-127.

Goldstone, Carvin. "Police must shoot to kill, worry later- Cele." *iol news.* 1 August 2009. www.iol.co.za/news/south-africa/police-must-shoot-to-kill-worry-later-cele-1.453587#.UvjHo2KSySo (accessed Jan 14, 2014).

Heathcare Professions Council of South Africa 2008, "Booklet 1. General Ethical Guidelines for the Healthcare Professions." Pretoria.

Heathcare Professions Council of South Africa 2008, "Booklet 1. General Ethical Guidelines for the Healthcare Professions." Pretoria.

International Dual Loyalty Working Group 2002, *Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms.* United States of America: Library of Congress Control Number:2003101403.

Independent Police Investigative Directorate (IPID) 2013, *Independent Police Investigative Directorate Annual Report 2012/13.* South Africa.

IPID . 'Minister Mthethwa Announces Robert McBride as New Head of the Independent Police Directorate'. Media statement, Pretoria, 28 February 2014, issued by the Ministry of Police.

Jenkins, Trefor and McLean, G.R. 2004, 'The Steve Biko affair' *Medicine ,Crime , and Punishment,* 364, pp.36-37.

Justo, Luis 2006, 'Doctors, Interrogation and Torture.' *British Medical Journal* vol. 332, no. 7556, pp. 1462-1463.

Langa, Malose n.d., *Analysis of Existing Data on Torture in South Africa.* Research Report, Johannesburg: The Centre for The Study of Violence and Reconciliation.

Lucas, Torsten, & Pross, Christian 1995, 'Caught Between Conscience and Complicity: Human Rights Violations and the Health Professions.' *Medicine & Global Survival,* vol. 2, no. 2, pp.106-113.

Marcus, Gilbert 1985, 'The Abdication of Responsibility: The Role of Doctors in the Uitenhage Unrest'. *South African Journal of Human Rights* (1) Part 2, August, pp.151- 153

Marinovich, Greg 2012, "The miners were hunted like beasts." *Mail and Guardian.* 31 Aug 2012. mg.co.za/article/2012-08-31-marikana-the-miners-were-hunted-like-beasts (accessed June 23, 2013).

Martin, L.J & Artz, Lillian 2007, " Chapter 3. Medico-legal services". In Sexual Offences Submission, 2007. Available at www.ghjru.uct.ac.za/ sexual-offence-bill/Medico-Legal-Services.pdf (www.ghjru.uct.ac.za/publication.htm) accessed 31 March 2014

McLean, G.R & Jenkins, Trefor 2003, "The Steve Biko Affair: A Case Study in Medical Ethics." *Developing World Ethics* vol.3, no.1, pp. 77-95.

McQuoid-Mason, David, and Dada, Mahomed 2011, *A-Z of Medical Law.* Juta & Company Ltd, Cape Town.

Miles, Steven H 2011, 'Settled precepts, normative ethics, applied ethics and physician complicity with torture.' *Medicine, conflict and survival* , vol. 27, no. 4, pp.191-196.

Moreno, Alejandro, and Iacopino, Vincent 2012. *PHR: Ending Impunity: The Use of Forensic Medical Evaluations to Document Torture and Ill Treatment in Kyrgyzstan.* Research Report, Physicians for Human Rights.

Muntingh, Lukas 2011, *Guide to the UN Convention against Torture in South Africa.* Centre for the Study of Violence and Reconciliation, Johannesburg.

Newham, Gareth 2013, 'Roots of the crisis facing the South African police', ISS Today, 7 March 2013. Institute for Security Studies. www.issafrica.org/iss-today/roots-of-the-crisis-facing-the-south-african-police. (accessed 09 September 2013)

Nickel, James 2014, '"Human Rights".' *The Stanford Encyclopedia of Philosophy (Spring 2014 Edition) Edward N.Zalta(ed.).* http://plato.stanford.edu/archives/spr2014/entries/rights-human/ (accessed 2014).

Nowak, Manfred, and McArthur, Elizabeth 2006, "The distinction between torture and cruel, inhuman or degrading treatment." *TORTURE,* Vol 16, No 3, pp.147-151.

Oosthuizen, H, and Verschoor, T 2008, 'Ethical principles becoming statuatory requirements.' *South African Family Practice,* vol. 50 , no. 5, pp.36-40.

Orbinski, James; Beyrer, Chris & Singh, Sonal 2007, ' Health and Human Rights. Violations of human rights: health practitioners as witnesses' *Lancet*, vol.370, pp. 698-704

Pigou, Piers 2002, *Monitoring Police Violence and Torture in South Africa.* Seminar Paper, Centre for the Study of Violence and Reconciliation.

Pithouse, Richard 2011, 'On the Murder of Andries Tatane'. *South African Civil Society Information Service (SACSIS).* SACSIS.org.za/site/article/655.1 (accessed May 5 2013)

Pothier, Mike 2013, 'Keeping an Eye on the Cops'. *Worldwide,* Vol 23, No.6, p.11

South African Broadcasting Corporation (SABC). SABC Radio News, 6 January 2014

Sen, Amartya 2004, 'Elements of a Theory of Human Rights.' *Philosophy & Public Affairs,* vol. 32, no. 4 , pp. 315-356.

Silove, Derrick 1990, 'Doctors and the state: Lessons from the Biko case.' *Social Science and Medicine,* vol. 30, no. 4, pp. 417-429.

South African Medical Association. *South African Medical Association.* 2012. www.samedical.org (accessed December 2, 2013).

"The Foundation of International Human Rights Law." *The Universal Declaration of Human Rights.* n.d. www.un.org/en/documents/udhr/hr_law.shtml (accessed June 11, 2013).

United Nations 2004, "Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Defrading Treatment or Punishment." *Office of the United Nations High Commissioner for Human Rights.* www.phrusa.org (accessed May 2, 2013).

United States Department of State, 2012 "2012 Country Reports on Human Rights Practices- South Africa." *Refworld.* 19 April 2013. http://www.refworld.org/docid/517e6dd578.html (accessed October 30, 2013).

van der Merwe, Hugo 2000, 'Evaluation of the Health Sector Hearing: Conceptualising Human Rights Reconciliation.' Research Report for Centre for Study of Violence and Reconciliation, 2000.

Woods, Donald 1991, *Biko.* Henry Holt & Co, United Kingdom.

World Medical Association. *WMA International Code of Medical Ethics.* 2006.

Wyngaardt, George 2014, ' Police Brutality in Kensington, Cape Town, South Africa' online video viewed on 7 March 2014. www.youtube.com/watch?v=7b97R2uyfkg (7 March 2014)

LAW

Constitution of the Republic of South Africa (Act 108 of 1996)

Criminal Law (Sexual Offences and Related Matters Amendment Act, 2007) (Act 32 of 2007)

Independent Police Investigative Directorate Act (IPID Act , Act 1 of 2011)

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

Prevention of Combating and Torture of Persons Act, 2013 (Act No. 13 of 2013) (sic)

The Children's Amendment Act, 2007 (Act 41 of 2007)

The Health Act (Act No.63 of 1977)

The Health Professions Act 1974 (Act 56 of 1974)

The National Health Act, 2003 (Act 61 of 2003)

The Older Persons Act, 2006 (Act 13 of 2006)

Criminal Procedure Amendment Act, 2012 (Act No. 9 of 2012) (formerly Criminal Procedure Act Amended)

The South African Police Services Act, 68 of 1995

CONVENTIONS, DECLARATIONS AND RESOLUTIONS

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

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

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

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

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)

The Universal Declaration of Human Rights

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

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

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)

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