

Abstract

The leadership of South Africa's medical profession remained silent in the face of gross human rights violations by the apartheid government or affirmatively defended the government's conduct. While there were strong cultural and economic reasons for this alliance between leaders of the medical profession and the apartheid state, the leadership also embraced western medical ethics. As a result, when confronted about its conduct, it continually sought to defend its behavior on traditional ethical grounds. This article looks at the nature of that "ethical defense" in three areas: torture in detention, racial discrimination in health services, and breach of confidentiality in the case of political activists. The article concludes that the rules of medical ethics left too great a space for making such a defense and urges that ethical rules consistent with the Universal Declaration of Human Rights be adopted.

Face aux violations flagrantes des droits humains par le régime de l'Apartheid, les représentants de la profession médicale en Afrique du Sud demeurèrent silencieux ou soutinrent ouvertement l'attitude du gouvernement. Alors qu'il y avait de solides raisons culturelles et économiques pour cette alliance entre les représentants de la profession médicale et le régime de l'Apartheid, ceux-ci firent aussi appel à l'éthique médicale occidentale. De ce fait, lorsqu'ils furent questionnés sur leur conduite, ils cherchèrent constamment à défendre leur position sur la base de principes éthiques traditionnels. Cet article examine la nature de cette "défense éthique" dans trois domaines: la torture en détention, la discrimination raciale dans les services de santé, et le non respect de la confidentialité dans le cas d'activistes politiques. L'article conclue que les règles de l'éthique médicale laissèrent trop d'espace permettant une telle défense et appelle à l'adoption de règles conformes avec la Déclaration Universelle des Droits de l'Homme.

Los/as representantes de la profesión médica sudafricana se mantuvieron silenciosos frente a las enormes violaciones de los derechos humanos del gobierno del apartheid o bien abiertamente defensores/as de la conducta del gobierno. A pesar de que hubo razones culturales y económicas fuertes para que se creara esta alianza entre líderes de la profesión médica y el régimen del apartheid, estos/as líderes también se aferraron a la ética médica occidental. Como resultado, cuando se les cuestionó sobre su conducta defendieron su comportamiento basándose en principios éticos tradicionales. Este artículo analiza la naturaleza de esta "defensa ética" en tres áreas: la tortura durante las detenciones, la discriminación racial en los servicios de salud, y la falta de respeto de la confidencialidad en el caso de activistas políticos/as. El artículo concluye que las reglas de la ética médica dejaron un espacio demasiado amplio como para defenderlo y promueve que se adopten reglas éticas conformes a la Declaración Universal de Derechos Humanos.

THE UDHR AND THE LIMITS OF MEDICAL ETHICS: The Case of South Africa

Leonard Rubenstein and Leslie London

Principles of medical ethics have served both as a vision of the role of the physician with the patient and as a benchmark for governing and judging professional behavior. What happens, though, when the medical leadership at the highest levels of society, ostensibly adhering to normative practices and international standards of medical ethics, becomes an apologist for conduct that deeply undermines those ethics and, with them, the human rights of millions of people? How is this conduct rationalized? This article reviews such conduct and its justification and suggests a need for incorporating principles derived from the Universal Declaration of Human Rights (UDHR) in medical ethics so that such professional behavior is less easily justified within the framework of ethics. Developing an ethic based on the UDHR points to the potential role institutions of the medical profession can play in providing leadership in promoting and protecting human rights within the normative ethical discourse of the profession.

South Africa is an appropriate place to examine these issues, since the behavior of the medical profession under apartheid, and particularly its leadership, illustrates how actions antithetical to human rights can be justified within an ethical paradigm. While this contradiction found its most extreme expression under apartheid's cozy alliance with the health professions, the lesson for other countries lies in the limitations of medical ethics as a framework for balancing the conflicting forces of professional self-interest, duties to-

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ward third parties, societal responsibilities, and a broader moral obligation toward the rights of disenfranchised or vulnerable groups. While the reprehensible results of compromise on moral obligations are more evident in repressive regimes, similar conflicts face health professionals in less oppressive countries.

As has been well documented, the South African medical profession under apartheid elevated support for a racist regime over the rights of vulnerable and dispossessed groups.^{1,2,3,4,5} Complicity in abuses involved both acts of commission and omission. For example, office-bearers of the Medical Association of South Africa (MASA), South Africa's major physician organization, remained silent in the face of medical evidence of beatings and assaults in prisons, the breaching of patient confidentiality at the behest of security forces, segregation of all forms of medical care, gross discrimination against black students seeking to train in medicine, and disparate pay and working conditions among the minority of their black colleagues who succeeded in qualifying as physicians under apartheid.^{6,7,8} They refused to address the massive health impact of laws and practices of apartheid that forced millions out of their homes, relegated them to squalid living conditions, and inflicted endless humiliations on them.^{9,10} All the while, they celebrated themselves as "honest brokers" outside politics.¹¹

The moral nadir for South Africa's medical leadership came after the death in detention of anti-apartheid leader Steve Biko in 1977. Extensive evidence from the inquest implicated two physicians who had attended Biko prior to his death. These physicians had engaged in unethical practice by acquiescing in the torture and assault in the circumstances leading to Biko's death.^{12,13,14} Despite national and international outrage, the key institutions of the profession, the MASA and the profession's disciplinary body, the South Africa Medical and Dental Council (SAMDC or Council), refused to take action against them. When many members pressed the MASA to demand that the Council reopen the matter, it refused. Instead, it impugned the motives of its critics and "mounted a vigorous nationwide propaganda campaign" to assure that its member physicians "would tow the MASA line."^{15,16,17,18} At one point the General Secretary of

MASA professed disbelief that “South Africans would willingly allow themselves to be party to” torture or abuse of prisoners and protested that the MASA’s critics did not produce evidence of torture in detention.¹⁹

The MASA has since acknowledged that its behavior in the Biko “affair” was “disgraceful,” driven by the need to ally with the state and reflecting the fact that the “MASA as such was always...a part of the white establishment of South Africa, and for the most part and in most contexts shared the world views and the political beliefs of that establishment.”²⁰ White South African physicians were, after all, part of the elite socialized in the ideology and practice of racial privilege. The circles in which they lived and the political values with which they grew up led them to be comfortable with the apartheid state. As the SAMDC put it in its Truth and Reconciliation Commission (TRC) submission: “The SAMDC functioned in a society of which virtually every member of the politically dominant class was steeped in doctrine and propaganda.”²¹ Their educational experience reinforced these values, rationalized beliefs in black inferiority and the ideology of separate development, and discouraged the questioning of authority. For white physicians, moreover, apartheid brought special benefits. South Africa was home to fine (white) hospitals, sophisticated clinical research (including the first heart transplant), a health care system for whites that its physicians compared to the best in the world, and career opportunities on a par with health systems in the developed world.

Yet throughout apartheid, the MASA and the SAMDC embraced not only western medicine but also medical ethics and, when under siege, defended their conduct on ethical grounds. Political considerations certainly informed this stance: the MASA needed to demonstrate adherence to international principles of medical ethics in order to withstand repeated calls for its ouster from international medical organizations. This strategy, coupled with carefully conceived window-dressing initiatives such as establishing supposedly “independent” panels to examine detainees, paid off politically — the MASA succeeded in its application for readmission to the World Medical Association in 1981, five years after it resigned.²² Indeed, in 1983, following the tumultuous

fighters in South Africa over the conduct of the Biko doctors and condemnation of the MASA's conduct from abroad, MASA's General Secretary, Dr. Viljoen, was appointed to the World Medical Association (WMA) Ethics Committee. Some medical organizations, particularly the American Medical Association, positively embraced the MASA. There is no question, however, that the moral standing of South Africa's medical profession was irrevocably damaged internationally and that MASA's readmission deeply split and almost destroyed the WMA.^{23,24,25}

Throughout all of this political maneuvering, South African physicians perceived themselves as acting morally and consistent with modern medical ethics. They adopted international codes, including the Declaration of Geneva (the modern version of the Hippocratic Oath), the International Code of Medical Ethics, the Declaration of Tokyo (condemning physician participation in torture and cruel and inhuman treatment and providing guidelines for avoiding complicity), and the UN Principles of Medical Ethics.^{26,27,28,29} Despite unending efforts by the Afrikaner intelligentsia to provide an intellectual underpinning for apartheid, it is significant that no apartheid-based medical ethic ever emerged in South Africa. Moreover, in the face of moral criticism the profession turned to normative international codes and believed itself to be upholding traditional ethical values:

South African statutory professional councils, organizations and training institutions thus perceived themselves as supporting universalized norms for professional behavior. Implicit in this belief was the notion that a Judeo-Christian western value system had been integrated into the very fabric and practice of the health professions.³⁰

Key to the MASA's ability to achieve and maintain legitimacy despite its abysmal abdication of moral responsibility was its reliance on ethical justifications and normative ethical paradigms to ward off criticism. Its interpretations reveal a great deal about the mindset of the South African medical leadership and the apparent malleability of ethical obligations, and suggest important lessons concerning medical ethics in general. It is to these contradictions that we now turn in detail, examining three of the most prominent ethical

issues of the time, and the response of the South African medical profession.

Torture and Assault in Detention

During apartheid, an estimated 73,000 people were incarcerated for indefinite periods without being charged with any crime.³¹ Many were tortured. The circumstances of their detention created terrible ethical conflicts for the district surgeons who were responsible for providing medical care to detainees.^{32,33,34} They were pressured not to examine detainees who had been assaulted or tortured and not to report any injuries they did find. Although nominally independent, district surgeons were often controlled by, and felt loyal to, the security forces. Physicians who participated in gross ethical violations in these circumstances were almost never subjected to professional discipline by the SAMDC.^{35,36}

Drawing on Article 5 of the UDHR, which prohibits torture, cruel, inhuman or degrading treatment, the Declaration of Tokyo of 1975 explicitly prohibits physician participation or complicity in torture, cruel, inhuman or degrading treatment. The *South African Medical Journal* repeatedly endorsed the Declaration and, in 1976, proudly noted that “nobody in our profession will require even a moment’s soul-searching before wholeheartedly supporting” it.³⁷ When responding to attacks concerning its conduct regarding the Biko doctors, the MASA’s General Secretary pronounced that the MASA “unreservedly supports the World Medical Association’s Declaration of Tokyo which provides guidelines for medical practitioners in respect of torture or other cruel, inhuman and degrading treatment or punishment of prisoners and detainees.”³⁸ The MASA, however, narrowly interpreted the Declaration to apply only to a doctor’s personal involvement in torture. Though the Declaration states that doctors should not “countenance” or “condone” torture, the scope of the obligation of institutions of the profession to work to end or prevent torture is not detailed. The MASA contended that criticism of state policies on detention would constitute impermissible involvement in politics and would compromise its ability to protect the interests of the profession. As an

editorial in the *South African Medical Journal* put it:

Should we as doctors be taking an active stand against the security legislation in this country, and against government policy? I strongly believe that the MASA has a particular sphere of interest, and must restrict itself to that sphere. Whatever the political dispensation in the country may be at any given time, we, as a professional body, must strive for the best possible health care. We, as doctors, must be able to meet on common ground when considering medical matters, irrespective of our individual political beliefs. We can then advise the authorities on the effects of their political and administrative activities, without being brought into the party political struggle. Perhaps it is not too much to hope that we will be perceived to be "honest brokers" for the well-being of our people.³⁹

Such apparent high-mindedness, of course, took no account of the impact of "security legislation" on its victims' health and well-being.

A stunningly ingenuous editorial in the *South African Medical Journal* at the height of the Biko controversy offers an indication of how the MASA sought to rationalize its failure to take decisive action against the torture of detainees. The MASA leadership urged support for the SAMDC on the grounds that the Council had supported the MASA's position on reimbursement issues and that "a modicum of political savvy" demanded that it avoid criticism of the Council.⁴⁰ It thus saw a need to balance its role in preserving medical ethics and protecting human rights — even the protection against torture — with its ability to be a "player" in government decision making.

In subsequent years, consistent pressure on the MASA from within and outside the country forced it to take tentative steps toward protecting the human rights of detainees. The 1983 MASA Ad Hoc Committee responsible for investigating the medical care of detainees released a report that acknowledged cases of maltreatment of detainees and the existence of ethical conflicts experienced by physicians working in detention facilities. Despite its decision to call for procedural safeguards to protect detainees and legislation to protect clinical independence of physicians, the MASA was nonetheless unwilling to condemn the circumstances of detention, which rendered ethical behavior impossible in the face

of the total control exercised by security forces.^{41,42} Even more important, the Ad Hoc Committee did not address the violations of the UDHR that led to interference with clinical independence: the use of arbitrary and indefinite detention without charge as a means of defeating a political movement, a practice that violates Article 9 of the UDHR (“no one shall be subjected to arbitrary arrest, detention, exile”), as well as Articles 7, 8, 10, and 11 (which guarantee fair trial, due process and equal protection of law). To challenge the regime’s use of arbitrary detention would have jeopardized the MASA’s own influence on the state. Moreover, as events developed, none of the recommendations arising from the Ad Hoc Committee that the MASA viewed as allowing it to discharge its “ethical” duty were ever implemented.

The MASA again ignored the human rights context in which it functioned when it produced a Code for the Handling of Children in Detention that failed to ask the obvious question of why children needed to be detained at all.⁴³ Rather than challenging the underlying human rights and health issues, it sought compromise designed to preserve its influence on national level policy concerning detention facilities.

By the late 1980s, international opprobrium, academic boycotts, and the rising tide of a national democratic revolution sweeping South Africa meant it was no longer in the interest of the South African medical profession to be as obdurately and unflinchingly supportive of apartheid. The MASA began to adopt a more nuanced and human rights-supportive approach to professional ethics and, together with academic institutions and progressive human rights physicians, developed a code for the management of hunger strikers in response to campaigns by political detainees for their release. This shift can be understood as serving its perceived self-interest.

Apartheid and Racial Discrimination

The Declaration of Geneva states: “I will not permit considerations of age, disease, or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing to intervene between my duty and my patient.”⁴⁴ The MASA repeatedly assured critics that it accepted its obligation not to discriminate.⁴⁵ In his 1982

manifesto, for example, Viljeon responded to allegations that the MASA refused to condemn apartheid with the protest that the "MASA has over many years consistently maintained and propagated a policy of nondiscrimination between medical practitioners on the basis of race or color and has actively involved itself in seeing to it that where such discrimination in fact occurred steps were taken to rectify matters."⁴⁶

The MASA, however, construed its own duty as applying only to nondiscrimination in accepting members. It did not accept any ethical duty to take a position on the broader evil of discrimination in health care, which clearly violates Articles 2 and 7 of the UDHR, much less on the gross misallocation of health resources under apartheid. In its statement to the TRC, the MASA acknowledged that its Federal Council had considered the issue of discrimination in salaries, hospital facilities and health care, and segregated waiting rooms as early as 1961, but waited until 1989, when the apparatus of apartheid had begun to be dismantled, to call for nondiscrimination in health care.⁴⁷ Indeed, when such an opportunity was presented in 1975, the MASA Federal Council Executive Committee turned down a proposal from its Transvaal branch to establish an equalization fund to achieve parity in salaries for black doctors because it would give rise to "practical difficulties *which would be detrimental to the cause of the Association*" (original italics).⁴⁸

The MASA thus saw its obligations regarding discrimination as it saw its duties regarding torture. It recognized that discrimination posed an ethical dilemma, but defined that ethical responsibility narrowly and found a countervailing interest in preserving its influence on the state. Viljoen thus noted that the MASA should not discriminate among its membership but, regarding the broader issue of segregation in South Africa, he argued: "[i]n order to promote the honor and interests of the medical profession successfully the MASA obviously has to maintain contact and, as far as possible, good relations with the government departments and officials concerned."⁴⁹ That, of course, meant keeping quiet about human rights violations. By exploiting ambiguities in ethical codes — in this case, whether they require medical organizations to oppose institutionalized discrimination — the MASA rejected the notion that active opposi-

tion to discrimination in health and health care was part of a professional obligation.

The SAMDC, as the regulatory body responsible for holding the profession accountable for ethical standards, took the even narrower view that racial discrimination by a physician in providing health care did not constitute professional misconduct.⁵⁰ Alarming, a senior staff member of the Council reiterated this view as recently as 1997.⁵¹

Moreover, this truncated concept of the duty not to discriminate in health care or in the distribution of health resources was not limited to the South African medical profession. In 1981, a delegation from the American Medical Association (AMA) not only denied evidence of discrimination in health care in South Africa, an ideological fiction that no one in post-apartheid South Africa would ever seek to defend, but also described apartheid health care as merely “a segregated system that many Americans will find unfortunate.”⁵² This startling and bizarre argument led to the conclusion that the monstrosity of apartheid created no *ethical* problem for the AMA. More generally, the AMA saw no obligation by physicians to oppose social and political practices that inequitably deny people health care.

Fidelity to One’s Patient

The response of the South African medical profession to torture and discrimination illustrates the traditional tendency of medical ethics to concern itself narrowly with the relationship between the physician and the patient, rather than with the human right to health and well-being.^{53,54} MASA officials were also adept at explaining why the clinical independence of physicians, a core concern of medical ethics, could be legitimately restricted by the state.

Fidelity to the patient has been a central ethical concern of medicine. Yet, as Bloche has shown, the duty of devotion to the individual is far from absolute.⁵⁵ Even in the clinical role — the physician and the patient — other health or social purposes may at times trump devotion to the patient’s well-being. The military doctor, or even the sports team physician, may have a greater interest in returning the individual to the battlefield than in protecting the individual’s long-term health. Mandatory reporting of infectious diseases to

preserve public health may be seen as outweighing the psychological benefits of maintaining confidentiality. Although typically formulated in absolutist language, the clinical duty of loyalty is in fact sometimes set aside in the name of other social objectives.

Unfortunately, as Bloche points out, ethical rules lack a mechanism for balancing duty to the patient with conflicting duties or social interests, and he has proposed standards and procedures for achieving such a balance. South African physicians exploited the ambiguity Bloche identifies and filled in the gaps with their own social values in order to justify their complicity with the state against the interests and wishes of their patients.

For example, security forces pressured South African physicians and hospitals to report persons injured in political demonstrations to the police. After physicians protested, an editorial appeared in the *South African Medical Journal* justifying this violation of confidentiality because the authorities need to protect innocent people from “unruly and often unlawful behavior” and to ensure respect for the law.⁵⁶ Even when some physicians protested deaths in detention, others bluntly defended the state: “[i]t is not part of our medical ethics to work individually or as a profession against any state, whatever its political complexion, which detains suspected dangers to it without charge or trial, or subjects them to periods of solitude [sic], or does not permit them to see physicians of their own choice....Nearly all states do, have done, and will continue to do these things unless they wish to commit suicide.”^{57,58}

In another instance, the anti-apartheid medical organization, the National Medical and Dental Association, urged the MASA to take a public stand against a subpoena ordering a doctor to divulge the names of detainees who had been the subjects of a scientific study on the effects of detention. Dr. Viljoen responded that the disclosure of names was necessary to enable the “authorities” to protect the victims of abuse, ignoring the likelihood that these same authorities would likely retaliate against the detainees.⁵⁹ These apologist responses were fiercely contested and even drew a objection from an ethicist, Ranann Gillon, whose work was cited in one of the editorials. Gillon argued that the “law

and order" justification for violating ethical rules could never be applied to apartheid laws, which were themselves morally illegitimate.⁶⁰

Exceptions to core ethical duties should be acceptable only for reasons that promote human dignity, in a manner consistent with the UDHR. But the absence of standards defining what constitutes a social objective sufficient to overcome the duty of loyalty to the patient and the lack of any reference to principles deriving from the UDHR allowed the apologists for apartheid to make their case.

Conclusion

Acceptance of the basic tenets of the apartheid state by so many South African physicians casts doubt on whether any ethical standards would have changed their behavior. Nonetheless, the ethical arguments cited to justify abdication of human rights and moral responsibilities points to the need for more stringent codes of medical ethics to protect human rights. Of course, physician organizations, like any other social or professional group, will act in their self-interest. But they also lay claim as a profession to special responsibilities and moral authority in society. Until ethical and human rights instruments demand that physicians set aside their perceived self-interest to protect human rights, we are likely to see further complicity in human rights violations.

The South African experience demonstrates the need for ethical codes that incorporate the principles of the UDHR and more clearly articulate physicians' obligations regarding human rights. This article does not attempt to outline such a framework. However, it is clear that it would demand professional behavior that advances health and human dignity both in the examining room and in the larger society. An ethic supporting human rights and true to the UDHR would not permit silence in the face of torture. It would not enable medical associations to claim that gross and invidious discrimination in the provision of health care and health care resources are not ethical violations. It would not allow patient confidentiality to be sacrificed to state repression. And it would not permit practices that violate human rights to constitute grounds for interfering with the duty of loyalty to the patient.

Such an ethic would also not permit health professionals to ignore human rights violations affecting health in the name of remaining above or outside “politics.” The ethic would reject the commonly-held view expressed by a South African physician: “Medical ethics has to do with the circumscribed situation in which an individual chooses to seek our professional advice and trusts us to do a good job. All else, including that referring to the relationship of medicine as a whole to society or humanity as a whole, is ideals, ideologies and politics.”⁶¹ A human rights ethic would turn away from this mindset and affirm that health professionals must speak and work for the realization and protection of human rights.

The need for an ethic of health and human rights based on the promise and principles of the UDHR is especially pressing now. As global socioeconomic polarization increases, the challenge is to ensure that this ethic applies not only to the most egregious situations of gross violations of human rights such as torture, but also to inequitable health care practices and violations of social and economic rights, where physicians should act to defend the rights of those who are vulnerable.

In forging such an ethic, one may also look to the South African experience. Many South African physicians, including many within the MASA, stood up to fight against apartheid because they believed it was their moral and professional obligation to do so. The anti-apartheid National Medical and Dental Association had more than 1000 members by 1989.⁶² These physicians did not engage in abstract and sophistic discussions of ethical obligations. Rather, they saw clearly the suffering and injustice of apartheid in its many manifestations. Many took significant personal risks and suffered damage to their careers. Others put their lives in jeopardy. It is from their values that an ethic of health and human rights may emerge.

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