

## Ethical Issues in the Management of Civil Unrest Injuries — L London



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### Curriculum vitae

Dr Leslie London graduated from the University of Cape Town in 1983 and completed his internship at Grootte Schuur Hospital. He obtained a BSc in Epidemiology at Stellenbosch University in 1987 and a Diploma in Occupational Health at the University of the Witwatersrand in 1989. He currently works as a full-time medical officer for a trade union-linked medical benefit fund and runs a primary health care facility in Paarl. He is secretary of the Western Cape Medical branch of the National Medical and Dental Association (NAMDA) and has been active in the programme providing medical and counselling services to ex-detainees and political prisoners.

### Summary

*Doctors have recently been confronted by ethical and medical issues during the recent "civil unrest" since 1985 - issues which are new to their experience and foreign to their training. People argue that medical science is objective and value-free, but it has become very clear that medical ethics is a site for intense subjective conflict. Medical opinion is far from neutral: it is strongly influenced by personal value systems, previous experiences, social and political factors. Medical ethics became a dynamic enterprise of applying general principles to real life events in a meaningful way. A few of the pressing problems are discussed, analyzed and illustrated by real life experiences. Some of the questions dealt with, are: May police seize medical records? Does a doctor have to report a gunshot? May the police be present during examinations of civil unrest injuries? May police prevent health care personnel entering areas where injured people are in need of treatment? How important is confidentiality in the doctor-patient relationship?*

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Ethics, Medical;  
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Politics.

### Introduction

Few people in South Africa can have remained untouched by the political upheavals of the past few years, not least the medical profession whose task it has been to treat most of the people injured in so-called "civil unrest" since 1985. The South African Institute of Race Relations estimates that at least 4 136 people died as a result of political violence in South Africa during the imposition of the successive states of emergency from September 1984 to June 1990.<sup>1</sup> Since the unbanning of organisations in February 1990, there has been no decline in the level of violence. Over 6 000 injuries and nearly 3 400 fatalities have been reported by the Human Rights Commission due to vigilante, security force or hit squad activities over the past 15 months in South Africa.<sup>2,3</sup>

For many doctors and health workers who have been caught up in the turbulence of township protests and security force actions, the state of emergency suddenly confronted one with a range of problems concerning patient care and medical ethics under constraints of civil conflict. Many of these questions were issues new to our experience and foreign to our training, and left us uncertain as to what course to follow. Some of these problems are expanded upon below.

### Ethical Problems in the Management of victims of civil unrest

A major area of concern revolved around police interference in the doctor-patient relationship.

A doctor who was involved in providing emergency care to unrest victims following the shooting of 43

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people in Langa, Uitenhage by security forces in March 1985, wrote "On the Saturday following the shootings, I went to the emergency clinic, only to be received by the police. The police were there in full force, including Colonel S.... He threatened to arrest me and any other practitioners who treated any of the wounded; he alleged that we were obstructing the course of the law.

"Something similar happened to a colleague of mine. On the Thursday following the first shootings, a man was brought to her with a bullet wound. The wound looked like the man had been hit with a panga, it was so big... Within a very short time, the security police arrived. They demanded that my colleague should hand the patient over to them, so that he could be sent to hospital. She insisted that the patient was not going to hospital, saying she did not believe that he would get the treatment he needed."<sup>4</sup>

Many doctors describe the experience of referring injured patients to hospital only for them to be arrested whilst in hospital.<sup>4</sup> Allegations were

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**At least 4 136 people died in political violence in South Africa from 1984 to 1990**

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made of complicity on the part of the hospital authorities who routinely informed the police of all civil unrest injuries.<sup>5</sup> At other times there was a continuous police presence in hospital casualty units, intimidating both staff and patients - "The manner in which police conducted themselves at both hospitals was

shocking. They displayed an aggressive and arrogant attitude, particularly towards patients and visitors. They interfered with normal doctor-patient relationships and created a general feeling of fear and tension within the hospitals".<sup>6</sup>

This had the effect of patients refusing to seek treatment at hospital for fear of being arrested. Following the Langa shootings, a doctor

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**Doctors are suddenly confronted with ethical and medical problems totally new to their experience and foreign to their training**

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described how "those who had been able to get away from the shootings that Thursday had fled into the hills, and there was no way in which they were going to be persuaded to go to the hospitals."<sup>4</sup> Another doctor working in Port Elizabeth recalled that "there were some people who came to the hospital three weeks after the massacre with gangrenous legs. This shows how scared they were to come to a hospital."<sup>7</sup> This phenomenon was particularly common in rural hospitals where collaboration with police appeared to be much worse.

Patients refusing hospitalisation for serious injuries often forced doctors into difficult clinical situations, where they were compelled to treat cases that they would normally have referred. A doctor described how, on one visit to the local aid office, there were ten to twelve young men with multiple bullet wounds. "Most of these young men needed to be

examined in hospital, as they had bullet injuries in the areas of the chest, diaphragm and hip... They needed X-rays to find out exactly where the bullets had been lodged, and possibly required removal of the bullets... We did not have any equipment. The only thing we had with us were penicillin and syringes. So all we could do for these people was to give injections of penicillin in order to prevent secondary infection... The question was how to get these patients into hospital and avoid them being found and arrested by the police."<sup>7</sup> The doctor then went on to describe the extraordinary lengths to which they went to get patients admitted to hospital with pseudo-diagnoses so as not to attract suspicion.

The other common area of concern was the threat to confidentiality of medical records around this time. On at least two occasions, security forces were involved in seizing medical records at the clinic of the South

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African Leadership Association (SACLA) in Crossroads, Cape Town in 1985 and at Alexandra Clinic outside Johannesburg in 1986. Referring to a security force raid on the SACLA clinic, a daily newspaper in Cape Town described how "The clinic was surrounded and police came into the clinic, pushed aside a doctor and searched the clinic. A police video camera filmed the events. Personal baggage was searched and

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staff members were questioned on confidential medical information on patients, which they refused to divulge. Police apparently sought information on patients who had been shot.<sup>98</sup> Other common related complaints at the time concerned police insistence on being present during examinations and the shackling of injured persons arrested by the police.

Other problems created for patient care included the closing off of access for medical staff to clinics and trouble-torn townships by security force cordons, the stoning of medical personnel, vehicles and health facilities and the interference with patients' access to health services by one or other group in the context of vigilante violence in the community. The SACLA clinic was effectively forced to close by threats of vigilante violence to staff and patients who opposed the authority of the Nxobongwana regime in Crossroads. SACLA's newsletter protested "Where does that leave the clinic? If we are asked to go back by the community, half our former patients remain unserved and denied access to us. We will pretend neutrality if only witdoeke are able to receive treatment".<sup>9</sup>

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"The police threatened to arrest any doctor who treats any of the wounded"

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This welter of developments raised many unforeseen ethical and medico-legal questions that were closely interwoven with the political context in which resistance to the apartheid government was unfolding. In

response, medical personnel had to draw on the guidance of a range of ethical codes and declarations in resolving these dilemmas. These codes are listed in table 1.<sup>10-15</sup> On the basis of these codes, it is possible to address some central questions of medical ethics and analyse the specific problems highlighted in the discussion above.

**Table 1: Ethical codes relevant during civil unrest**

- \* General Declaration - WMA
- \* International Code of Medical Ethics - WMA
- \* Hippocratic Oath
- \* Tokyo Declaration - WMA
- \* Havana Declaration - WMA
- \* Geneva Protocols - International Red Cross Society.

**Medical confidentiality**

Medical confidentiality is a central aspect of medical ethics and is found in a range of ethical codes.<sup>10-13</sup> Its importance in medical practice is undisputed. However, what is not as clear is whether confidentiality is an absolute or a relative concept. There are authors and ethicists who have argued that medical confidentiality is an absolute principle that cannot be broken under any circumstances.<sup>16</sup> However, in practice, society and medicine have come to recognise confidentiality as a relative principle ie a principle to be pursued at all times and only to be broken under exceptional circumstances.<sup>17</sup> Such exceptional circumstances may, according to the General Medical Council (GMC), include:

1. Where the patient gives consent.
2. Where information is needed by other doctors for patient care.
3. Where the doctor believes that a close relative or friend should know about the patient's health but it is medically undesirable to seek the patient's consent.
4. Exceptionally, where the doctor believes that disclosure to a third party would be in the patient's interests.
5. Statutory requirements (eg: infectious disease notification).
6. Where a judge in a court of law directs a doctor to disclose information.
7. (Rarely) where the public interest overrides duties of confidentiality.
8. For medical research approved by an ethics committee.<sup>17</sup>

While these recommendations serve as guidelines, they are not intended to be definitive statements on what constitutes acceptable ethical norms and numerous authors would disagree with some of the instances forwarded by the GMC. Nonetheless, it is specifically the questions of statutory reporting and "public interest" that has stirred much

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"The police created a general feeling of fear and tension in the hospitals"

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controversy in South Africa. Let us now examine some of the more pertinent ethical dilemmas for patient care illustrated in the experience of various doctors quoted at the start of this article.

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## Does a doctor have to report a gunshot injury in his/her patient to the police?

In terms of statutory requirements, there is *no* compulsion on doctors to report a gunshot injury to the police,<sup>18</sup> unlike the situation with infectious diseases or child abuse where legislation specifically allows for such process. What is often confused with a statutory requirement is the common law notion of becoming an accessory to a crime by virtue of remaining passive or allowing another party to accomplish something prohibited, or to escape. Arguments have been made that a doctor could become an accessory to a crime should the doctor not report the gunshot injury of an individual who is subsequently shown to have been involved in a criminal activity.<sup>19</sup> Dr Gluckman points out that "actual knowledge on the part of the accessory after the fact is not required: it is sufficient if the physician had 'constructive' knowledge in the sense that he foresaw the possibility of the crime's commission."<sup>20</sup> Clearly, this possibility remains contingent on the interpretation of the court.

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Wounded patients came to the hospital 3 weeks after their injuries, with gangrenous legs - too scared to come sooner

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Moreover, if "it is clear from the medical or other history that no offence has been committed, notwithstanding all the foregoing and despite any general instruction, there is no obligation on the physician to refer the case."<sup>20</sup> Since

the courts are likely to view sympathetically a doctor who had responded thoughtfully within the ethical norms of their profession, it seems as if the question of a doctor becoming an accessory to an unrest-related crime is a marginal possibility.

On the question of compulsory reporting, Emson, writing in the *Journal of Medical Ethics*, points out that compulsory reporting by statute can become perverted for political purposes and "by this means doctors can be recruited into the information system of an ethically unacceptable regime... An agreement to submit to the rule of law is not to submit to all, or to unjust laws."<sup>21</sup> He goes on to remind us that Eichman's defence was that he was merely obeying orders.<sup>17</sup> The Geneva protocols regulating behaviour during armed conflict similarly condemn mandatory reporting of information by doctors.<sup>14</sup> The underlying message is that legal and ethical requirements do not necessarily concur. The presence of statute does not absolve the doctor from an active responsibility to preserve confidentiality.

Another argument advanced for the reporting of gunshot injuries has been the notion of "public interest" justifying the breaking of confidentiality.<sup>19</sup> Here, one enters the terrain of politics, sociology and doctors' own value systems. One needs to ask in what way could the standard reporting of gunshot injuries benefit the public? *Which* public and *whose* interests served? Given the obviously political nature of the violence of the "unrest" in South Africa,<sup>21,22</sup> the frequently documented cases of injuries to uninvolved bystanders or non-violent protestors,<sup>4</sup> and the standard practice of the police to arrest anyone with

gunshot wounds,<sup>23,25</sup> it seems impossible to justify the breaking of confidentiality for the apparent goal of saving lives in future.<sup>19</sup> In the way Dr Gillon points out in the *British Medical Journal*, "few people would expect doctors to disobey just laws",<sup>26</sup> it is clear that the justice or injustice of laws are crucial in determining whether statutory breaching of confidentiality is medically unethical or not.<sup>27</sup>

## Are police entitled to seize medical records?

At its simplest, the answer is no. Medical records represent confidential information recorded by the doctor during consultation with the patient. As such, it should not be divulged unless the doctor is ordered to do so by the presiding officer in a court of law (judge).<sup>28</sup> A doctor is not under a general obligation to reveal information to police arriving at a health facility on a "fishing expedition" in search of people wounded during unrest.<sup>18</sup> It may be that to disclose such information is highly unethical.

In practice, it may be difficult for medical staff to assert the right to confidentiality in the face of police who believe that they are able to take any actions under the existing legislation.

## Are police entitled to be present during examination of civil unrest injuries?

The doctor-patient interaction should be seen in the same light as records and similar considerations of confidentiality apply. Accordingly, police would not have the right to be present during examination. Whilst police may argue that they are present

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to prevent escape or to protect the medical staff from assault by the prisoner, this does not constitute an *ethical* argument for insisting on being present during examination. Groote Schuur Hospital has developed a protocol for the management of detainees/prisoners in hospital that enables the attending doctor to sign an acknowledgement of the possible consequences of examining a "prisoner-patient" without police protection.<sup>29</sup>

## Can the police remove your patient?

Effectively, yes.

The doctor's first duty is to render medical care and assistance to his/her patient.<sup>10,11,13,18</sup> If the arrest of the patient is likely to interfere with treatment, or if the doctor feels the patient will not receive appropriate treatment after being arrested, then the doctor would be justified in insisting that the patient remain under his/her care. However, in practice, police will claim that appropriate medical services are available through the district surgeon. Under such circumstances, it is not feasible to oppose removal of your patient, but, at the very least, the doctor would be obliged to:<sup>18,20,30</sup>

- compile a medical history of the patient, including treatment to date as well as recommendations for continued treatment,
- make such information available to the district surgeon concerned,
- inform the police officer concerned of the possible consequences of removing the patient, and, if possible, to verify this in writing,
- inform the family of the patient.

Even if the arrest is technically illegal, as it could be if the patient is simply being arrested for having gunshot wounds on the presumption that they have been involved in a crime,<sup>20</sup> this does not constitute *ethical* grounds for opposing arrest. However, there is nothing to stop the doctor from arguing for the rule of law in such cases.<sup>18</sup>

## Can medical personnel be refused access to areas where injured persons are in need of treatment?

Action by any force to prevent medical personnel from having access to treat injured people runs counter to the spirit of medical ethics<sup>10,15</sup> and the Geneva convention regarding armed conflict.<sup>14</sup> However there is no

## Fearful patients forced doctors into treating them - patients they would normally have referred

legal guarantee for medical personnel to gain access to injured people. Police roadblocks have effectively sealed off townships in the past<sup>4,23</sup> and in practice, no legal remedies can guarantee that medical staff get through such cordons.

## Can medical services be partial?

The Geneva Declaration, to which the Medical Association of South Africa is a signatory, states clearly that "I will not permit considerations of religion, race, party politics or social standing to intervene between my duty and my patient."<sup>10</sup> This injunction would apply equally to *all*

sides in a conflict. In practice, it is often circumstances beyond the control of medical staff that impinge on the neutrality of medical care under these circumstances.<sup>9</sup>

## Are those injured persons arrested in hospital, patients or prisoners first?

Whilst in hospital, injured persons are first and foremost patients under the care of the hospital staff who are, in terms of the Tokyo Declaration, obliged to exercise full clinical independence over the management of the patient.<sup>15</sup> This applies to all aspects of the doctor-patient interaction, including the question of confidentiality. Where the conditions under which the patient is held as prisoner interfere with their medical care (eg: shackling to the bed), the attending doctor is obliged to insist on the removal of such interference. In this respect, much has been learnt from the experience of treating hunger strikers in hospital.<sup>31</sup>

What of the ethical difficulties posed by situations of being forced to treat patients who refuse to go to hospital? A response has been to pressurise the hospital to behave ethically and preserve patient confidentiality, thereby addressing the problem of the lack of trust patients have in the hospital.<sup>5,6</sup> Nonetheless, there are no simple answers for doctors facing this situation. No-one would consider it reasonable to refuse to treat such patients, yet no-one would condone treating a condition for which one was not qualified or did not have appropriate facilities to deal with.<sup>32</sup> One of the practical ways in which this phenomenon has translated into reality has been the programme of training in first aid to community groups, co-ordinated by the

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Emergency Services Groups (ESG). In many areas, general practitioners have been drawn in to assist locally and have developed sound relationships with these groups, who act as effective primary contact first-aiders, treating minor injuries, referring all other injuries expeditiously and ensuring that people in the community receive appropriate care.<sup>23</sup>

Another vexed question is the broader issue of whether doctors can remain politically neutral in the context of ethical and human rights abuses. The ethical codes of medical practice clearly point to a conflict with the laws and political policies of this country, the clearest being the question of apartheid and racial inequalities intervening in patient care.<sup>23,33</sup> Specifically in the context of civil unrest, where large numbers of people are involved in action to change an iniquitous social system, apartheid, to a more egalitarian one, this contradiction is further accentuated.

Moreover, on the specific question of medical ethics, we have seen how a single editorial on the reporting of

Medical confidentiality is central to medical ethics and its importance in medical practice is undisputed

gunshot injuries<sup>20</sup> has been interpreted in completely different ways by doctors subscribing to the same medical ethical codes.<sup>19,23-25,27</sup> While some would argue that medical science is objective and value-free, it is clear that medical ethics is a site for

intense subjective conflict. Medical opinion is far from neutral, being influenced by one's personal value systems and experiences and a range of social and political factors. Far from being a static discipline of quoting codes from paper, medical ethics is a dynamic enterprise of applying general principles to real life events in a meaningful way. Given this understanding, it is impossible to see doctors as remaining politically neutral in South Africa today.

Medical ethics during civil unrest

- \* Medical ethics at a time of conflict remain the same as at a time of peace.<sup>34</sup>
- \* Confidentiality remains a central tenet of medical ethics and any infringement of medical ethics must be ethically justifiable.<sup>17,26</sup>
- \* Legal statute and ethics do not necessarily coincide and the presence of statute does not absolve the doctor from his/her ethical responsibilities.<sup>17</sup>
- \* The interpretation of what constitutes ethical behaviour is guided by established ethical codes but can only be decided in confronting the practical realities of specific situations.

We should also note the international concern expressed for the preservation of human rights, a concern that has focussed particularly on South Africa for its apartheid policies and on the South Africa's medical profession, following the appalling handling of the ethical

issues raised by the treatment of Steve Biko prior to his death in detention in 1977.<sup>35,36</sup> International Human Rights Conventions have been developed to challenge health

Police seized confidential medical records by force

professionals to improve the standard of care to detainees, prisoners and victims of human rights abuses<sup>37</sup> and we should see the question of the medical ethics of treatment of civil unrest victims in this context. We need to strive to meet this challenge. But ethical codes are not sterile documents on paper. It is precisely through confronting real issues of patient care under civil unrest conditions that we learn to interpret and apply ethical principles. As we witness the profound political changes taking place in our country at present, it remains to be seen how the medical profession will meet that challenge.

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