

The meaning of the MASA apology

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The South African medical profession last year offered a collective apology for its role in supporting apartheid in the past — by restricting admissions to medical schools on the basis of race, by segregating health facilities voluntarily, and by tolerating police interference in the treatment of detainees and prisoners. This article questions the validity of a collective apology on behalf of the profession when individual doctors have not disclosed their own involvement in human rights violations. As the newly established Truth and Reconciliation Commission listens to the stories of more and more victims who experienced abuse at the hands of state doctors during the apartheid era, the medical profession has an ethical obligation to take strong, corrective action to deal with its past.

This article proposes that the Medical Association of South Africa and the Medical and Dental Council undertake a 'parallel process' of healing that involves truth-telling, forgiveness, and reparation. The article argues that the creation of a Truth Commission for Doctors would have a healing effect on the profession, that it would help ensure that human rights violations of the past never happen again, and that the profession assumes greater responsibility for the ethical conduct and training of future doctors.

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The apology by the Medical Association of South Africa (MASA) for past 'acts of omission or commission'¹ was welcomed with joy and relief by some sections of its membership. That this was by no means universal² suggests that certain members may still believe that their past actions were right.

The enthusiasm with which the statement was received by some individuals is reminiscent of that which greeted the response of the State in October 1985 (during the partial State of Emergency) that a 'panel of independent doctors' would be available for consultation by detainees. The MASA described this move as a 'major breakthrough'.³ Failure to deliver on that promise⁴ has, understandably, left doubts in some minds about the true value of the recent announcement. The Chairman's 'carefully worded statement' purported to have 'brought to a climax the Medical

Association's deliberate process of transformation¹⁵ has caused unease among colleagues concerned with human rights. In a single sentence the MASA exonerates itself from the untold harm of the Apartheid era: 'Examples include the restriction of medical school admissions on the basis of race; the segregation of hospitals and other health facilities; the maintenance of separate waiting rooms by doctors; and toleration of interference with doctors' treatment of prisoners and detainees.'¹¹ It creates a bad impression because it is dismissive of the thousands who had been detained and tortured since 1960.⁶ It does not foster the culture of human dignity that the President and the Government of National Unity are promoting.

Most damaging within medical ranks is the fact that the apology denies members the opportunity to reflect on and question the real meaning of human rights and medical ethics. The vagueness of the statement prompted commentators in the same issue of the *SAMJ* (August 1995) to associate it mainly with the Biko incident. Doctors who plead ignorance could easily fall into the same trap of disregarding the complicity of professional organisations and individuals. The challenge for the MASA is to find constructive ways of informing members and the public about the dark past.

The criticism levelled at the apology is, therefore, that it is little more than an acknowledgement of previous wrongs and lacks the crucial element of disclosure.

For doctors who are committed to the establishment of ethical norms, a pardon entails a visible change in behaviour from one of silence and denial to one of acknowledgement and disclosure.⁷ Disclosure involves scrutiny of past actions and remorse, something that will lend weight to the words.

Responsibility for the disgrace and the increasing isolation of South African medical practitioners in the late 1970s lies not only with the two district surgeons who attended Biko. The onus was also on the professional organisations that failed to discipline their unethical conduct.⁸ This omission had international political repercussions for the profession. It happened at a time when South African doctors had little more than the 1975 Declaration of Tokyo to guide them.⁹ Today equality, dignity and human rights are legal requirements enshrined in the Interim Constitution; the chapter on Fundamental Rights is a yardstick of ethical standards.¹⁰ In future the sincerity of the apology will be judged by the actions which follow it, and by the openness and honesty with which the history, often hidden,¹¹ is re-examined.

The time is ripe to review those events which had such a profound effect on the medical profession. In order to make some sense of the complex roles of the South African Medical and Dental Council (SAMDC) and the MASA in the aftermath of the Biko inquest, their responses are set out separately in chronological order. But first it will be helpful to review the composition and functions of the separate organisations.

The SAMDC was established in 1928 by an Act of Parliament.¹² It is the 'guardian of the prestige, status and dignity of the profession'¹³ and the protector of the public against unethical practice and negligence. Its work, therefore, entails the setting of standards for professional qualifications and ethical conduct and the registration of medical and dental practitioners who are adequately

qualified.¹² All doctors practising in South Africa must pay an annual registration fee to the SAMDC. In addition, it advises and informs the Minister on important health-related matters.¹⁴ Until September 1995 the SAMDC consisted of 34 members (Act 56 of 1974): 20 official appointees and 14 elected by registered doctors and dentists (J. P. van Niekerk — personal communication).¹² Complaints related to breach of professional conduct, often emanating from the public, are submitted to the SAMDC. All these complaints are screened by a Committee of Preliminary Inquiry which consists of 5 members and is appointed annually. This committee assists the SAMDC to establish whether sufficient evidence exists for further inquiry (compare the function of the Attorney General). The case is then referred to a Disciplinary Committee for investigation.^{15,16} The Disciplinary Committee has 'quasi-judicial' powers to investigate allegations of improper or disgraceful conduct against registered practitioners. It may caution or reprimand the party concerned, or recommend suspension or removal from the medical register. Before the recommended penalties are imposed they must be approved by the full Council.^{15,17}

The MASA is a voluntary professional organisation established in 1927 and looks after the business interests of doctors. With the representative bodies of other member countries, it is affiliated to the World Medical Association (WMA). Until the 1980s the MASA did not accept medico-ethical responsibilities¹⁵ as these were perceived to be the province of the SAMDC.

In terms of the Inquest Act (1959) all deaths not attributed to natural causes require legal investigation.¹⁹ The death in detention of Steve Biko on 12 September 1977 was therefore followed by an inquest (17 November to 2 December) to establish the probable cause of death. It was held before the Chief Magistrate of Pretoria and two assessors, both forensic pathologists. Death was found to have been caused by extensive brain damage. No single person was found guilty of an act or omission resulting in Biko's death.¹³

As required by law, the magistrate forwarded relevant portions of the inquest record relating to the medical conduct of the two district surgeons to the SAMDC for possible disciplinary action.¹⁵ At the same time the Ombudsman of the South African Council of Churches, Eugene Roelofse, who had previously referred the inquest evidence to the SAMDC, delivered a formal complaint to the Council. He requested that it establish whether the conduct of the doctors concerned met professional standards.¹⁵ Under the pretext that the case was *sub judice*, while civil claims of the Biko family against the Ministers of Health and Police were in progress (March 1978 to July 1979),^{20,21} the SAMDC did not respond until April 1980. It then announced that the Committee of Preliminary Investigation found no reason to take further action.¹⁵ Two months later the full SAMDC considered and adopted the decision of the Committee of Preliminary Investigation by 18 votes to 9.¹⁵ In response, Dr B. T. Naidoo resigned as a member of the SAMDC²² and the Boards of the Medical Schools of the universities of Witwatersrand and Cape Town dissociated themselves from the decision of the SAMDC.²⁰

Early in 1982 five doctors took action. They submitted detailed documentation to the SAMDC requesting that it

hold a full and open enquiry into the ethical conduct of the district surgeons who treated Biko. In addition, black doctors, dentists, pharmacists, nurses and paramedicals, all members of the Health Workers' Association, lodged a list of complaints against the two doctors with the SAMDC. A year later, in March 1983, the Committee of Preliminary Investigation found no new evidence to support the complaints and no reason for reopening the case.¹³ The SAMDC adopted this recommendation in April.

In November 1983, six of the doctors who had earlier petitioned the SAMDC appealed to the Supreme Court to set aside the SAMDC's decision. They claimed that the SAMDC had neglected its statutory duty when it failed to discipline the district surgeons and that this damaged the reputation of the South African medical profession.¹³ By requesting that the court order a disciplinary hearing the focus shifted from the district surgeons to the SAMDC.⁸ From the evidence placed before it, the Supreme Court found that the SAMDC had 'not applied its mind' and in January 1985 ordered it to establish a disciplinary committee to investigate the conduct of the doctors.¹⁵ The disciplinary committee, presided over by the President of the SAMDC (chair), with Judge Trollop as assessor, sat from 1 to 5 July 1985.²¹ It found the two district surgeons guilty of: (i) failure to take a proper history or to ask the patient what had happened; (ii) failure to examine the patient properly; (iii) failure to keep proper bedside notes; (iv) issuing a false medical certificate; (v) failure to monitor the patient's condition (recommended by the consultants); (vi) not examining the patient before transferring him; and (vii) not insisting on transportation by ambulance with a proper escort.

Dr Lang was found guilty of improper conduct. He was cautioned and discharged. Dr Tucker was found guilty of 'disgraceful and improper conduct'. He was suspended from practice for 3 months, and this sentence was suspended for 2 years.²¹ In October 1985, the full SAMDC considered the recommended penalty and decided, instead, to strike Dr Tucker off the medical register.^{13,20}

Although the MASA had made submissions to the SAMDC,²³ its involvement in events following the Biko case was of a different nature. To place events in perspective we return to October 1975, when the Japanese government denied members of the MASA visas to attend the WMA meeting in Tokyo.²² At this meeting the WMA adopted the Tokyo Declaration of '[g]uidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment'.⁹

Under increasing international pressure, the MASA withdrew from the WMA in October 1976, a year before Biko's death.²³

Five years later, in 1981, the MASA rejoined the WMA. At the same meeting, the Transkei Medical Association was admitted as a new member, despite the fact that South Africa alone recognised Transkei's independence. The meeting drafted a code of patients' rights and declared itself the 'protector' of medical ethics. Among other things, medical participation in capital punishment was declared unethical.²⁵

Within months of the readmission of the MASA to the WMA, Dr Neil Aggett allegedly hanged himself while in

detention at John Vorster Square, Johannesburg, on 5 February 1982.²⁶ This happened 2 days after the Minister of Law and Order had assured parliament that 'every possible measure was taken to ensure detainees could not injure themselves or commit suicide'.^{27,28} No reasons were given why the magistrate²⁹ and Inspector of Detainees had been denied access to him.^{30,31}

The MASA was now under tremendous domestic and international pressure. In May 1982 it announced the establishment of an *ad hoc* committee under the chairmanship of S. A. Strauss, Professor of Law at the University of South Africa, to inquire into the medical and ethical care of prisoners and detainees. The task of the *ad hoc* committee was to set 'minimum standards for health services' (my emphasis) and 'to promote preventive health care'.³² The report submitted to the Minister of Health³³ was published in a supplement to the *SAMJ* on 21 May 1983. Evidence had been collected from concerned individuals, organisations, district surgeons, forensic pathologists and state departments. It was apparent that there were deficiencies in the medical care and, on occasion, serious maltreatment of detainees. They felt that defects in the system were due to a lack of appropriate legislation and safeguards. They commented on the adverse psychological effects of solitary confinement and of prolonged, intensive interrogation. They proposed that the medical care of detainees and prisoners be statutorily defined under one law and that all inmates be informed of their medical rights. Legislation would guarantee the district surgeons full clinical independence and unrestricted access to detainees. In cases of obstruction of duty, the MASA would support appeals by a district surgeon to the Department of National Health and Population Development (DNHPD). The safeguards recommended were that: (i) detainees have access to a private doctor of their own choice; (ii) a peer review body be established with access to detainees and to records, and that it be permitted to examine detainees; (iii) weekly physical and psychological assessments be introduced for those in isolation; and (iv) assaults and injuries be recorded while at the same time confidentiality was respected.³²

It took 1½ years for the state to respond to this report. In October 1985, the government agreed to the formation of a panel of independent doctors to which detainees would have access.³⁴ All the other recommendations were turned down.³⁵ In announcing this 'breakthrough', the MASA stated that detainees would in future be able to obtain a different medical opinion 'if for any reason they were not satisfied with the care provided by district surgeons'.³⁶ The state retained control by setting several preconditions for a doctor to become a member of the panel: (i) (s)he had to be a member of the MASA and approved by the MASA executive;³⁴ (ii) treatment prescribed by panel doctors was subject to approval by the district surgeon;³⁴ and (iii) (s)he had to obtain security clearance.³⁷

The names of panellists were not made public.³⁷ The MASA's understanding that detainees would be informed of the existence of the MASA panel on arrest was not implemented.³⁸ It is not clear whether the names of panellists were supplied to detainees on request, or whether the district surgeon provided information and a list of names once the detainee had asked to see a different doctor.³⁵

I, declare that I have been informed that the services of a district surgeon will be at my disposal should I need such services for some or other reason during the period of my detention in terms of Section 29 of the Internal Security Act 1982 (Act 74 of 1982). The services of a district surgeon would be rendered free of charge.

I am further informed that there is a panel of private surgeons at my disposal should I not be satisfied with the services of a district surgeon. I am further advised that I am entitled to make use of the services of *only one* of the surgeons on the panel of private surgeons and that I shall direct any request for the services of a panel surgeon to the district surgeon, who in turn will then contact the designated panel surgeon. I understand that should I make use of this offer, I would be held personally liable for *all the costs* which may result from using the services of such private surgeon. I understand that before acceding to my request, a guarantee for such costs can be asked of me.

PLACE
 DATE
 TIME
 SIGNATURE OF DETAINEE

.....
 SIGNATURE AND RANK OF MEMBER
 INFORMING DETAINEE OF HIS RIGHTS

WITNESS

1059

Fig. 1. Form given to detainees advising them of available health services.⁴⁰ (Because of the poor quality of the original, it is retyped here; the text is unchanged. Emphases are in the original.)

By February 1987 panels for consultation were in place at 20 of the MASA's 21 regional branches.³⁹ Two years later the MASA admitted that the panels were not functioning.⁴⁰ The MASA's failure to agree on a mechanism and a date of implementation made a mockery of its efforts and intentions to provide an alternative medical service for detainees. In addition, it appeared that in some regions the Security Police were not aware of the existence of these medical panels (S. Kay, Convenor of the Panel, Southern Transvaal Branch of the MASA — personal communication). Finally, in June 1989, the state informed the MASA that the Security Police had been instructed to inform all Section 29 detainees about the panels. These detainees were to sign a written declaration to this effect, witnessed by two others, and bear the cost of the consultation (Fig. 1). It was argued that the district surgeon could, if he thought it necessary, refer the emergency detainee for a second opinion, and that there was no need for further concessions.⁴¹ There is, however, a significant difference between a detainee's having the choice of two or more doctors and a district surgeon's referring a (detainee) patient because he wishes to obtain a second (specialist) opinion on the case. Referral has always been the district surgeon's prerogative.⁴²

It is extraordinary that, despite the misgivings of some,⁴³ the MASA assumed that the government of the day, determined to root out extra-parliamentary opposition, would honour an agreement without a firm undertaking to a process or date of implementation.

At the height of its efforts to obtain independent medical opinions on detained patients, the MASA had yet another opportunity to demonstrate its ethical commitment to the well-being, health and safety of detainees.⁹ A month before

the proclaimed announcement of the 'panel of independent doctors', Dr Wendy Orr made an urgent application to the Supreme Court on 27 September 1985 that the police in Port Elizabeth stop ill-treating the hundreds of detainees under their care. The MASA did not hail the court interdict which restricted police brutality as a means of protecting detainees. It merely reiterated the statement of the *ad hoc* committee against physical and mental abuse.⁴⁴ Neither did the MASA pursue the difficulties Dr Orr encountered when she approached official channels to investigate the assaults.⁴⁵ It was also not able to intervene on behalf of Dr Orr whose job was threatened while she was not a MASA member.⁴⁴

Human rights organisations were and will remain sceptical about ethical contradictions of this nature. There should be no ambivalence about a doctor's ethical responsibility to his patient over that to the state.^{9,46} Political developments isolated South Africans after the United Nations General Assembly adopted the International Human Rights Charter in 1948. Now that we are again part of the family of nations, the MASA has the grave responsibility of setting an example by educating its membership about human rights. A vigorous educational campaign should be the foundation of medical ethics. Putting this theory into practice will be more difficult, particularly in caring versus custodial situations. Our past is littered with incidents where doctors neglected their caring duty. Collusion with the state was regarded as a patriotic duty by some of them. Pointing fingers now only adds to the stress under which district surgeons work. It will not improve service or the working conditions of those who are, and were, prepared to work in prisons. There has to be recognition of the pressure and tension under which these doctors fulfil an unglamorous and unrewarding task. Yet the mismanagement of the past cannot be overlooked. The complex process of developing a code of moral conduct entails acknowledging human dignity on both sides of the prison divide.

The transitional phase of reconciliation offers doctors an opportunity to make amends by developing ethical norms. All professional bodies need to accept their responsibility for the harm done.⁴⁶ This includes medical accountability, lack of training and failure to support colleagues. One way to meet this challenge is by means of disclosure and pardon; something like the Commission for Truth and Reconciliation which aims to grant amnesty 'in return for the truth'.⁴⁷

The Commission for Truth and Reconciliation started functioning in April 1996. To complete its task within the allotted time, it will deal only with gross human rights violations: political murder and abductions, deaths in detention and torture.⁴⁷ This will leave many loose ends. Of medical concern is the role of health care providers, during and even after the states of emergency. Professional organisations should be encouraged to establish their own truth commissions and to create a forum where everybody (perpetrators and victims) will be given an opportunity to talk about the constraints, frustrations and hardships they faced or suffered.

Enough members of parliament were maltreated in prison for them to consider this option seriously. They may even encourage a process that aims to respect human dignity and relieve suffering in jail. As victims they are fully aware of the level of anger beneath the surface of brutalised activists.

The brush-off of a glib 'apology' could spur some of these victims to lay evidence of disgraceful and improper conduct before the SAMDC. Documentation exists that could be as damaging to the medical profession as the Biko case, if not more so. Three or four such cases will do irreparable damage to the reputation of South African doctors. It is an unhappy prospect which would benefit no one, especially at a time when MASA will be chairing the WMA.

On the other hand, a medical 'truth commission' aimed at redressing past hurts is likely to gain support from national and international human rights organisations. Organisations such as the American Association for the Advancement of Science (AAAS), Physicians for Human Rights, Amnesty International and Human Rights Watch have always opposed detention without trial, torture and extrajudicial killing, and supported civil liberties. Among other things, they have provided treatment of survivors of torture. The AAAS, for example, assisted Argentina with expertise to identify the 'disappeared' of the military regime between 1976 and 1983.⁴⁹ In the same vein, efforts by South Africans to humanise prisons are likely to be encouraged and draw support.

Once the idea of personal stories that can be used to develop an understanding of the ethical role of health providers and the meaning of human rights has been accepted in principle, the process requires careful planning. To encourage individuals from both sides to come forward, it is crucial to establish a safe place where these stories can be told. For district surgeons it means a place where, without ridicule, they can unburden themselves of the frustrations and shame of the past, and where their courage to be honest will be respected. The knowledge that their names will remain confidential may reassure some witnesses. The stories of victims are likely to reopen deep wounds and therefore need an empathetic audience. For all participants, a debriefing mechanism has to be in place.

The pain and remorse of this process will be living proof of a commitment to ensure that '[w]hatever happened to Steve Biko should never be allowed to happen in any country that regards itself as civilised'.¹¹

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