

Evaluation of the Health Sector Hearing: Conceptualising Human Rights and Reconciliation

by

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South Africa's Truth and Reconciliation Commission (TRC) engaged in an ambitious process of addressing the country's violent past through investigating past human rights abuses, listening to victims' stories and developing recommendations to prevent future abuses. As part of this process, the TRC held various sectoral hearings to highlight the role of these sectors in South Africa's past. The health sector hearing was one such hearing and has been hailed as an important step in the process of promoting reconciliation, transforming health services in South Africa and promoting a human rights culture among health professionals. While recognizing some significant achievements by the TRC in this regard, this paper raises concerns about the way that the hearing (and the health sector in South Africa more generally) has conceptualised reconciliation and how it has approached the question of promoting human rights.¹

Background

The hearing was in many ways one of the success stories of the TRC. In the [various evaluations](#) of aspects of the TRC conducted by the Centre for the Study of Violence (CSVr),² the health sector hearing stands out as an intervention that was significantly better planned, more participative, and more practical in its contribution to further transformation and self-reflection. The amount of time and resources that went into the preparations for the hearing, and the expertise (both internally and through the contribution of other health care professionals) brought to bear on the hearing, made the hearing qualitatively different from many of the TRC's other interventions.

The conceptualisation and planning of the hearing started before the TRC even came into existence. The idea of holding a hearing for the health sector first emerged from discussions at an international conference on torture held in Cape Town in November 1995 (VIIth International Symposium on Torture - Caring for the survivors of torture: Challenges for the health professions).³ In early 1996 the TRC took the decision to hold a special hearing on the role of the health sector. After extensive consultations with various stakeholders, a consultative meeting was held in Cape Town to draw together the various stakeholders to build consensus on the shape of the hearing. Participants at the meeting then elected a Task Team to work with the TRC in preparing the hearing. This Task Team played a significant role in strategizing and carrying out tasks such as drawing up guidelines for submissions, soliciting submissions, co-ordinating research, selecting submissions to be heard, organizing the program, and drafting questions to be put to the submitters.⁴ These

preparations resulted in the TRC receiving written submissions from 85 individuals and organizations.

Goals of the Hearing

The sectoral hearings were aimed at gaining an understanding of the broader social context that facilitated or gave rise to gross human rights violations in South Africa. While the legislation that created the TRC did not make specific provision for sectoral hearings, it did stipulate that the TRC should establish "as complete a picture as possible of the causes, nature and extent of the gross violations of human rights which were committed during the period of 1 March 1960 to the cut-off date (10 May 1994), including the antecedents, circumstances, factors and context of such violations, as well as ... the perspectives of the persons responsible for the commission of the violations." The legislation also required that the TRC must compile "a report providing as comprehensive an account as possible ... and which contains recommendations of measures to prevent the future violations of human rights."⁵

The health sector hearing was held with this broad set of objectives in mind. Rather than focusing on the direct participation of health care professionals in gross human rights violations (which was perceived to be of a limited extent), the hearing attempted to incorporate an examination of the ways in which health care professionals contributed to the environment in which those violations could occur. The public was invited to make submissions which covered everything from particular incidents and environments to the way in which medicine was practiced under apartheid.

These goals opened up the debate to cover almost every conceivable contested issue during the apartheid past (and resulted in submissions from quarters such as the Vegetarian Society, the National Traditional Healers Association, a broad range of individuals and numerous international organizations).

More specifically, the TRC requested submission to cover certain areas:

- Defining abuse
- Ethical obligations of health professionals
- Links between health professional ethics and human rights
- Why abuse occurred (vulnerable groups, tolerance of abuse, role of health professionals in exposing abuse)
- Specific health care situations (prisons, forensic and military doctors, torture)
- Recommendations regarding ethics and human rights education; educating service users; role of professional associations; checks, balances and accountability; and rehabilitation of torture victims.

Submitters were also requested to provide an "honest, searching reflection" of their role in the past, and to prepare their reports with an awareness of the underlying social inequalities that affected the health care sector under apartheid. As the TRC engaged with different parties and set up the hearing, its own prioritisation of goals became more apparent. The way in which the TRC developed a more specific agenda is explored later in this chapter.

Structure of the Hearing

The hearing was held over a two-day period in June 1997. It attracted extensive media coverage and was attended by a large number of health sector professionals, human rights observers and other interested parties. During the two days 25 of the submissions were presented in oral testimony.⁶ Submissions were heard from a wide range of stakeholders including the Medical Association of South Africa (MASA - a body representing most doctors), the Interim Medical and Dental Council of South Africa (IMDSCA - the statutory body responsible for certification and standards among medical practitioners), the Democratic Nursing Organisation of South Africa (DENOSA – a newly established/amalgamated body representing nurses), the South African Medical Services (SAMS - medical division of the South African National Defence Force), university medical faculties, practitioners and individual victims of human rights abuses.

Presenters were given 15 minutes to present their submissions and were then questioned by the Commissioners. Different Commissioners were assigned the task of questioning each submission. The first day of the hearing mainly focussed on the stories of individual victims and the experiences of individual health care professionals. The second day focussed on submissions by health care organizations.

Many participants were frustrated with the way that time was managed during the two days. In part, two days was simply not enough to cover the breadth and complexity of history of abuses and discriminatory practices that characterized apartheid health services. There were however also additional concerns that the way time was allocated to specific presenters resulted in a very superficial examination of certain key institutions and did not allow some presenters adequate time to relate their experiences and insights. Particularly where some presenters took excessive time to relate extraneous information and thus obfuscate their role, it was felt that the hearing was inadequately chaired.

Dr Wendy Orr, the co-ordinator of the hearing, concedes that more time should have been given to the hearing and that a more inclusive process would have been beneficial:

I would have liked to have a longer hearing. We only had two days and everybody says it was not enough. More people should have participated and perhaps we could have worked harder after the hearing to include more people in drafting the final report. Everything we did was under severe constraints.
(Orr 1999)

Another concern of participants was the manner in which the Commissioners conducted the questioning of submitters at the hearing. To some, it appeared that the Commissioners did not have a clear understanding of what the purpose of the process was, and that they had not sufficiently prepared for the hearing. Some presenters were questioned quite harshly regarding their institutions' histories of discrimination (and their intentions to make reparations) while others appeared to be let off the hook. This seems to reflect some inadequacies in the TRC's preparations regarding setting clear objectives, examining the written submissions, and prioritising which institutions needed to be pushed to come clean about their past.

A major legal obstacle in the proceedings was the fact that the TRC had not been able to provide alleged perpetrators who were named in the submission with the required advanced notice of the allegations against them. This meant that those giving testimony could not mention the names of perpetrators. It was however noted that some of these individuals (and their lawyers) were present in the audience at the hearing.

TRC Final Report and Recommendations

The section of the TRC's Final Report that deals with the Health Sector is only 55 pages long. It attempts to provide an overview of the context that led to the infringement of human rights. It includes only two pages of formal findings of responsibility. The findings are only of institutional failures to live up to ethical responsibilities. No findings of individual culpability are made. This is despite the fact that submission to the TRC named individual doctors.

The recommendations relating to the Health Sector are contained in a separate section of the Final Report. Stakeholders in the sector received these recommendations with relatively little enthusiasm. Several respondents interviewed as part of this report (more than six months after the release of the report) had not read the TRC's report or recommendations. To solicit reactions to the recommendations, the interviewers had to first provide a copy to interviewees.

Perceptions of the recommendations were generally positive, but interviewees saw them as mainly an important step in the process of transformation, rather than as an exhaustive or authoritative directive. Rather than being a blueprint, the report is seen as a document that provides a broad framework for institutions pursuing a culture of human rights.

One interviewee was however deeply critical of the TRC's recommendations:

The did not come out with any great gems of wisdom. ... I don't want to get too cynical, but I get angry. We had a great opportunity at the TRC. (Dassoo, 1999)

Another key participant in the process downplayed the significance of the final report in relation to the rest of the TRC process.

I found them quite cursory and summary. I didn't really have great expectations on what was going to come out of the process. It was more the process than the fact that there was a document that could then be used for other processes. I don't think they should be taken at face value because I don't think they are the standard. It's not as if we are creating a new standard. (London, 1999)

Post-Hearing Activities

The Task Team that helped implement the hearing continued to operate after the hearing. Its goal was to take forward the common goals that were identified in the hearing and start looking at ways in which human rights can be promoted in the health care sector.

However, the Task Team, confronted with a lack of infrastructure and resources to bring

together a range of role players, failed to make much headway in the two years after the hearing. The role of the Task Team was taken on in part by the Health and Human Rights Project who conducted extensive research on human rights abuses and published a book containing extensive recommendations regarding the implementation of a human rights culture. The South African Medical Association also established a Human Rights, Ethics and Law Committee that helped drive the process in collaboration with other organisations. By mid-1999 this process had however made little progress.

Stakeholder Participation in the Hearing

Significant efforts were made to solicit input from key health care institutions and to engage them in a serious process of critical self-reflection by challenging them to examine their past role in relation to human rights abuses as well as their vision for the future. The TRC engaged with the concerns that these institutions had about the purpose of the hearing, and negotiated ways in which investigations (by TRC investigators and by the institutions themselves) could be facilitated. TRC Commissioners also invested time in personally contacting potential submitters to encourage them to make submissions and to explain the process to them.

The other Commissioners and I attempted to consult every conceivable role player. This included the traditional structures, the progressive networks, unions and government structures. It was, however, very difficult to get much input from many of these structures. One big obstacle was our geographic location - Cape Town. We did what we could to include other regions, but we did not have a very big budget. (Orr, 1998)

This level of public consultation along with the input of the Task Team was exceptional when compared to the rest of the TRC's operation. Its community (gross human rights violations) hearings, for example, usually only provided for a period of a few weeks of community consultations, and only dealt with key local political leaders (rather than a wide range of local stakeholders). These consultations did not provide any space for the community to make an input regarding which cases should be heard, what questions to be asked, what community concerns to address, or what long-term reconciliation or investigation strategy to employ. The community was presented with a set formula, and they were asked to assist in arranging a venue, organizing transport, and assisting in gathering victim statements. Also when compared to the other sectoral hearings, the health sector hearing involved much broader consultations and stakeholder input.

Most respondents interviewed felt that they had been adequately consulted and they had been included in the process of decision making. One outcome of this level of planning and depth and breadth of consultation was that the hearing did provide a forum for serious engagement among health professional from a wide range of backgrounds. Despite some concerns about the lack of critical reflection evidenced by the submissions of certain institutions (most notably that of the SA Medical and Dental Council and the SA Medical Services), the fact that these institutions were persuaded to participate in the hearing, open up their archives to some degree, and subject themselves to public questioning, was notable. Their inability to address certain questions exposed their present transformation processes as inadequate and led to greater public debate about their future role.

The hearing was also very future-oriented in soliciting recommendations regarding prevention of future abuses. Furthermore, a joint process for ongoing cooperation between key stakeholders was formulated at the end of the hearing:

The health sector hearing was also unique because we set up a working group at the end of the hearing. The working group meets once a month, and will culminate in a national meeting in 1998. The aim of the working group is to take the TRC's recommendations forward. (Orr, 1998)

Some stakeholders took strong exception to this picture of inclusivity of the consultation process. They felt that they (and other stakeholders) had not been sufficiently consulted and that the process had displayed certain biases.

The process of consultation and invitation for the hearings was very exclusive. Only white liberal doctors were involved. Even the meetings that they held before the hearing comprised only white doctors from the Cape who knew nothing about the struggle against the apartheid system. The people from the struggle side (organizations like SAHSSO and NEHAWU) were thus not represented in the hearings. (Dassoo, 1998)

This was countered by Commissioners who felt that they had done all that could be expected from them to consult relevant role players.

The preparations for the hearing were very thorough. A meeting to make preparations for the proceedings was held in Cape Town where all the role players in the medical field were invited. In that meeting a committee was elected and charged with the responsibility to consult and invite all parties that were involved in the medical field during the apartheid era. All other organizations had attended that meeting except NEHAWU, which despite several calls did not participate. Also, before the hearing I personally spoke to NEHAWU in a bid to draw them into the process, but my efforts proved fruitless. (Randera, 1998)

The consultation and participation process of the TRC appears to have been guided by a policy of inclusivity. A bias is, however, likely to have been produced by the personal networks of the Commissioners involved in the process. Certain parties felt that the TRC's bias lent itself towards a doctor-oriented view of the health sector.

During the process that preceded the hearing, I learned that a meeting was held with the intention to include all the stakeholders of the whole medical set up. But we as physiotherapists were not invited to that meeting and thus the doctors who attended took a decision on behalf of other sections The TRC did not include ordinary people in its preparations for the hearing. The people who were excluded from this process are the ones who suffered from the hierarchy of the medical set up. (van Speyk, 1998)

Problems with representivity in the preparation stage also undermined confidence in the follow-through activities:

The task team emanated from those who engineered the health sector hearings, so they are going to be flawed to the extent that those health sector hearings were flawed. (Dassoo, 1999)

The priorities of the TRC regarding participation and the implications of its possible biases are examined in more detail later in the paper.

Critical Reflection

The process of critical reflection is crucial in any transformation process. While certain forms of change can be forced, deeper changes in value systems and issue of identity would also have to involve some level of voluntary engagement by the parties. There were various indications that the TRC hearing was successful in facilitating and convincing parties to cooperate in this process of examining their own role in past abuses.

TRC Commissioners realized that the TRC is but one step in a much longer process of transformation. Commissioners recognized that the hearing had a limited role in setting in motion a longer-term process:

In many ways the TRC is just a catalyst. This process (of the hearing) is part of several other processes. It encourages and kick-starts activities in communities, families, individuals, and civil society as a whole. (Wildchutt, 1998)

The TRC was thus aiming to set in motion a deeper process of self-reflection by the various organizations involved in the health sector. It was hoped that, through the process of drawing up and making submissions to the hearing, these organizations would engage in a process of evaluating their own past and charting a new course for the future:

We engaged in extensive consultations with role players in order to avoid receiving a hostile reaction to questions. We wanted the organizations to take responsibility for their own transformation. Professional structures should take ownership of this process. That is the only way that it will continue beyond the life of the TRC. ... The hearing also had an impact on those organizations that made submissions. The process of preparing submissions led to self-examination and an acknowledgment of the need to reconcile within organization. Examples include Wits Medical School, University of Natal-Durban Medical School, MASA, Physiotherapy Association, and the nursing sector. This was a process of recognizing latent resentment. The internal reflection served as catalyst to help the process of transformation. (Orr, 1998)

The hope that the submissions would spark a recognition of hidden internal tensions and set in motion internal reconciliation processes was realized in some institutions. Most notable of these outflows was that of the Internal Reconciliation Commission established by the Faculty of Health Sciences at the University of the Witwatersrand. Prof. Max Price, Dean of the Faculty explained the impact of the hearing as follows:

Participation in the hearing has been very valuable for Wits. First of all - and it has nothing to do with the hearings - the process of putting together our

submission resulted in a lot of discussion in the Faculty. What we realized was that we needed to bring a number of issues out into the open that had never been properly discussed in the open before. I don't mean in the outside public but in the faculty. So our Faculty Board decided, at the same time as we were approving that first submission, to set up an Internal Reconciliation Commission. (Price, 1998)

Other organizations also were confronted by their history under apartheid, and the hearing process is credited for assisting in this process of self-examination.

MASA leadership has started the process of self-criticism, but it will take a long time for it to sift down to the members. They have not really been engaged in the process yet. Among other things it requires an education process for medical schools to orient new doctors. In an effort to bring existing doctors on board, we will make sure that all doctors should receive a copy of the MASA report (to the TRC). There has at least been some discussion at the branch level in the process of compiling the report. (Dempster, 1998)

The process of critical reflection is however not just an event, but a process that will take some time and which will require some sacrifices by those who benefited from or contributed to discrimination and abuses. As one Commissioner commented:

Apologies are step one, but unless steps 2 - 1000 are taken, they are not worth the paper they are written on. It is important after MASA's apology to ask: what happens next. There is a need to repent and to repair the damage that was done. Within MASA there are already indications of change. (Orr, 1998)

Even among those organizations whose submissions were widely criticized, there is at least some acknowledgement of the need to reflect and transform. Nic Prinsloo of the Interim Medical and Dental Council commented: "The TRC helped the Council to reflect on its past. This would have happened whether the TRC was there or not, but not to the same extent and it would have taken a lot longer" (Prinsloo, 1998). The level of commitment to transformation of certain actors is however questionable. Some critical reflection and admission of responsibility does not necessarily imply a commitment to more fundamental transformation. As Dr Dassoo observed: There was

... an attempted frank admission of culpability by the Medical Association of South Africa in the Steve Biko affair By no stretch of the imagination could the Steve Biko affair and the admission of culpability there reduce the burden of guilt that the Medical Association needs to carry. Far, far more profound structural damage is the structural damage they did to the country. (Dassoo, 1998)

There is another underlying danger that still lurks in the sector: the eagerness to move forward and leave the past behind. After the TRC hearing, the IMDCSA turned down a request from the AAAS and Physicians for Human Rights to examine their archives. They also felt that further investigations of abuses would not be appropriate. They thought that the TRC was a process that should close the chapter of South Africa's history, and that it

would be counterproductive to continuously blame individuals and organizations for past wrongdoings (Prinsloo, 1998). Looking back at the past is thus not seen as a process of assigning blame and responsibility, but rather as a process that can help clarify different perspectives that would help create a basis for future cooperation.

While welcoming the TRC challenge to engage in self-reflection, some organizations felt that the TRC had not played a sufficient role in facilitating research or assisting in the preparation of the submissions. A representative from the nursing body (DENOSA), for example, commented:

We had an ambitious program. The TRC had promised the organizations in the medical sector some researchers who were supposed to help them compile their reports at least one month before the submissions. In our case, the person who was supposed to help us with the research and the compilation of the report was only sent in October 1997, i.e. after the hearings. The TRC had sent a researcher for only three days (instead of the promised 4 weeks) following our repeated requests. That is why our final (real) report was only submitted in November 1997. (Clow, 1998)

Some participants were critical of the extent of self-examination or the framework within which it occurred:

Only nurses were to some extent self-critical. They explored things like dual membership between the Nursing Council and the Broederbond⁷ that led to twisting of things politically to serve the interests of the apartheid system. They also examined their own structure in more depth, something that the doctors failed to do. (van Speyk, 1998)

One Commissioner also expressed some disquiet about the pace of change.

Regardless of the fact that we have been through such an intensive process in South Africa, often, many of the things have not been internalised and one gets the sense that for many of our people it's a question of business as usual The Health Professionals Council is there to protect the rights of the community that the doctors serve, and to maintain the professional standards of the profession, but I am still left wondering whether that professional council has really internalised that. (Randera, 1999)

Investigations and Exposure

While encouraging organizations to engage in critical reflection about their role in past abuses and discriminatory practices is clearly an important component of the longer term transformation process, the other side of the coin - investigation, confrontation and exposure - also need to be part of the process. The TRC did fairly little in uncovering the breadth of these abuses in the health sector or calling individuals and organizations to account for the role in past abuses. The TRC approach was generally one that vacillated between confrontation and gentle persuasion.⁸ The health sector hearing showed little of the confrontational side of the TRC and showed remarkable faith in the various role players

in past abuses to investigate and reform themselves.⁹

The TRC only played a limited role in conducting investigations regarding individual doctors' roles in past human rights violations. The hearing also did not focus on uncovering the abuses of specific doctors.

It was not within our mandate to investigate the conduct of individual doctors. We also simply did not have the resources. All those who were named detrimentally by submissions were sent Section 30 notices. The names of these people will be collated and sent to the Medical and Dental Council who will investigate and assess each case. They have already investigated one case referred to them by the TRC. (Orr, 1998)

The focus of the hearing was on institutions and their role in the past. Some activists however wanted vindication for the stands they took. In addition, they wanted individuals who had breached the ethical codes to be held accountable. (Baldwin and de Gruchy, 1998)

One thing that the hearing achieved was that it ensured future access for NGOs into some of the archives of the medical organizations such as the Medical and Dental Council. (Randera, 1998)

It may also be argued that focusing on disciplinary measures against individual doctors diverts attention from the need for more structural changes. One interviewee argued that taking action against district surgeons who failed to fulfil their ethical responsibilities was not the right response:

You put a band-aid on the situation by saying don't let these people who colluded in the past be part of a situation where pressure could be applied. Remove the situation where pressure could be applied, period. That's what they should have said. (Dassoo, 1999)

Investigations, prosecutions or discussion around individual cases are seen more in the context understanding the past and promoting a culture of human rights.¹⁰

I am not particularly focused around the need to extract accountability from District Surgeons and what happened in the past. I think they need to be held accountable in some form but it's not the be all and end all. ... the importance of holding people accountable is to create a culture that is different rather than being an end in itself. If the HPC is serious about it, then we could set up a structure that could deal with those cases the TRC couldn't handle and come to some conclusion. There could be cases where there are some grounds, cases where there aren't grounds, cases where it's clearly not reasonable. It would cost a lot of time and money, but it should be done.

I have friends who were doctors in operational areas in Namibia and who told me second-hand accounts of torture going on there. I think it is very important to document that, not to nail the medics, but to document that could happen under a normative western medical practice. (London, 1999)

The hearing focused more on institutional, rather than individual accountability. Stakeholders generally recognized this as a more vital component of promoting transformation:

I think it has questioned institutions. I think that is the more important result, rather than individual doctors. I think it is more important to say, look at what the institutions did. I think the health professions have a wonderful way of presenting that façade of professionalism that is ostensibly scientific and objective. So I think what was important about the Health Sector Hearings was to show that, no, actually the agenda and the profession was greatly influenced by apartheid ideology and what they did in practice was a result of that ideological influence. That was a very important aspect of the profession. I think it's been important in that way. (de Gruchy, 1999)

Participants in the hearing were however mainly critical of the TRC's inability to effectively call certain organizations to account during the hearing. They felt that certain presenters at the hearing were let off the hook.

... delicate areas of the health care sector like the military and prison should have undergone a thorough process of scrutiny. Instead, people from these structures were just selectively presenting what they believed will suit them and not what had actually happened in their work environments. There was not enough time to question the presenters properly. (Clow, 1998)

And there was basically no time for any questions and for the commission to get any deeper inside, or time to answer the few questions that were asked in any depth. It appears that they did not spend a lot of time in preparing the hearing. ... the presentations were very summarized, and I don't think that there was any real interrogation. (Price, 1998)

There were problems in that Commissioners were uneven in the way they challenged the presenters. For example, Wits got grilled, while SAMDC got off lightly. It depended on the Commissioner. They did not all understand the content of presentations. (Baldwin and de Gruchy, 1998)

Where the relevant organizations were committed to change and open to being confronted by victims' voices, an internally driven process of reflection appeared to have some merit. But where the old guard still held sway, or where the new black leadership displayed a limited commitment to introducing a human rights agenda (such as the case of SAMS), further investigation, exposure and confrontation is likely to be essential in promoting transformation.

Of course, you run into problems because the current government also has a vested interest in the military. There was a whole hooaha recently about certain documents that were put into the public realm by the TRC and that they shouldn't have done that because they current government wants them to remain confidential for their own benefit. So it's very tricky. (de Gruchy, 1999)

The process of transformation of the SAMDC (reconstituted as the Health Professionals Council) in 1998, was of particular concern to many interviewees. Because of its key role in regulating various health professionals and dealing with allegations of abuse, this institution is seen as a key role player in promoting human rights. Most interviewees were sceptical of progress in this regard. Some saw it as a long process that is just starting, while others felt pessimistic about the likelihood of change in a body where health professionals were in charge of regulating themselves.

I think the Medical and Dental Council has changed very little to be honest. I know they changed the constitution and they've appointed a new head. I am hoping that, perhaps, with these new people, there will be transformation, but I don't see any of it up to now. (Orr, 1999)

By all accounts, the people are different and many of them come from a transformation background. The institution is horribly unchanged. (London, 1999)

General Kluver was elected onto the new Health Professionals Council. ... We (SAMA) wrote to the HPC to make them aware that a finding had been made by the TRC against General Kluver,¹¹ and expressed concern that he was now sitting on such an important statutory body. (Randera, 1999)

The process of changing the health care sector in South Africa, and particularly the role of the doctors in society is generally recognized as a long-term problem. In a profession dominated by whites, the process of transformation is partially dependent on change within the demographics of the professionals.

We are looking at a sector which is still dominated by whites and the positions of power are still generally held by whites, and the profession as a whole is dominated by whites. But it is changing according to the classes we see graduating. It is going to take a long time. (Orr, 1999)

The impact on institutional transformation, while being difficult to measure, is recognized as the key contribution of the hearing:

I think it has questioned institutions. I think that is the more important result, rather than individual doctors. I think it is more important to say, look at what the institutions did. I think the health professions have a wonderful way of presenting that façade of professionalism that is ostensibly scientific and objective. So I think what was important about the Health Sector Hearings was to show that, no, actually the agenda and the profession was greatly influenced by apartheid ideology and what they did in practice was a result of that ideological influence. That was a very important aspect of the profession. I think it's been important in that way. (de Gruchy, 1999)

Improved Dialogue Among Health Sector Organizations

The consultation process around the hearing also appears to have facilitated improved

dialogue between organizations whose relationship was characterized by a history of mistrust and suspicion. The various medical bodies appear to have operated in isolation in the pre-TRC period. Space was thus created by the TRC to deal with some of the deep-seated animosities arising from experiences of internal victimization of health care professionals by their colleagues. The present level of consensus about the way forward is, it appears, largely a consequence of these ongoing deliberations among stakeholders who previously had quite strained relationships. Interaction in planning the way forward also appears to have improved perceptions of common ground among different bodies.

The TRC hearing also provided certain organizations that had made internal efforts at transformation to demonstrate to others how far they had come and to openly commit themselves to further changes.

The level of agreement about the way forward seems to be greater than agreement about the past. There are clearly some unresolved tensions regarding the past relationship between different groupings. Different organizations claim the moral high ground in terms of promoting the idea of a health sector hearing. People were clearly not communicating effectively before the TRC process got underway. Since the establishment of the Task Team by the TRC, attitudes appear to have undergone some transformation.

The relationship between health sector organizations has been significantly improved as a result of the whole TRC-initiated process. Present problems are not related to mistrust. Mistrust does still exist, but is not the obstacle to the process. There are now positive attitudes towards accommodating others. There was initially mild mistrust in the Task Team, but now there is none. In the field as a whole there is still a lot of mistrust among people from different organizations, but among the people who have worked together we have built good relationships. The TRC helped people listen to one another and thus overcome their isolation. A truly healthy trust was built through the hearing. One could see who had made efforts to change - who had bitten the bullet. (Dempster, 1998)

The hearing did raise some tensions but it helped clarify different perspectives. It helped create a basis for further cooperation. ... Reconciliation means that on an individual basis all of us can understand each other and move forward together. At an organizational level it means there must be better cooperation among different groups for the good of the profession and the patients. It requires that we overcome political differences. (Prinsloo, 1998)

The agreement among stakeholders in the health care sector is however on a limited agenda. The process of transforming the national health system in South Africa is still at an early stage, and intense political struggles arise in response to each government initiative in this sector.

The intra-sectoral reconciliation process is one that may mask certain problematic assumptions by the TRC in addressing human rights and reconciliation within the health sector.

The Human Rights and Reconciliation Agenda

While the health sector hearing was in many ways successful in achieving its goals, there have been some concerns expressed about the agenda set for the hearing by the various stakeholders, and the agenda for change that emerged from the hearing. These concerns raise the question of whether the health sector hearing provided an appropriate understanding of human rights concerns in the health sector and whether it effectively conceptualised how a human rights culture can be promoted.

These questions can be approached from a number of angles. Three critiques that I will explore are:

- 1) Human rights needs to be about empowerment as well as ethics
- 2) A reconciliation process needs to address psychological needs
- 3) A human rights agenda should examine access to healthcare as a key dimension of the problem

Human Rights and Empowerment

When looking at the transcript of the hearing it is remarkable how often reference is made of the terms shame, honour, pride and tribute. These terms reflect a constant theme in the submission as well as in the contributions of the Commissioners - the rehabilitation of the health profession. One avenue to rehabilitation identified by the Commission was the recognition of heroes. Rather than simply focussing on the victims and the perpetrators of abuse, the TRC also treated heroes as central role players in the hearing. In opening the hearing, Archbishop Tutu's introductory comments included numerous references to the honourable or heroic individuals in the health sector:

I myself have a very high regard for the medical profession in our country whose very high standards compare favourably with those in other countries. After all we pioneered things like heart transplants. What we have heard [is] that there has been collusion between healers and the security forces. ... That is the sombre side. There is a bright side in the witness of the medical profession, where people like Professor Ames and others ensured that people who had behaved, in what was to their view, unethical conduct, were to be brought to book. And sitting next to me is my colleague here who was very instrumental in getting an interdict against torture against the police, to prevent them from torturing detainees so that there are very, very considerable bright spots. I want to pay a very warm tribute to those in the health care professions who have distinguished themselves ... That we face the past honestly, acknowledging responsibility for the frequent failure of the health sector to uphold human rights, celebrating those who did fight for their patients' rights ...

The positive contributions of health professionals are explicitly engaged as part of the agenda of the hearing. In his introductory remarks Tutu outlines the agenda as "looking at the role of the health sector in perpetrating, colluding with, *or resisting human rights abuses.*"

In the process of soliciting submissions the TRC also sent out letters which invited input that included, among other things, a "celebration of those who did uphold human rights in the health care sector."

These positive bright spots are dotted throughout the hearing. The role of Dr Orr, the Commissioner in charge of the hearing, was frequently mentioned, as are the brave actions of other health care professionals who spoke out against the system and stood up for their patients' rights. The collection of press clippings displayed at the hearing was also very focussed on the role of doctors such as Wendy Orr, and their courageous stand against apartheid.¹²

This, it appears, was probably the only hearing of the TRC where an explicit goal was to identify and honour heroes. On the surface this would seem completely appropriate in a process of promoting reconciliation and unproblematic in the context of the goals of the hearing. It did however evoke some resentment and does raise questions about the reconciliation agenda. The fact that most of the heroes mentioned in the hearing were white doctors raises particular problems.

Portraying doctors as the heroes makes sense if one looks at the process of reconciliation and human rights promotion as one of instilling a sense of ethical pride in the profession. Reconciliation within this perspective is a process of rehabilitating the medical profession. On the one hand it is a process of creating new role models for the profession, and of rehabilitating the reputation of these heroes who were maligned by the apartheid government. On the other, it was a process of shaming those professionals who had transgressed the codes of the profession. All these elements can act as strong educational tools directed at health professionals and at the public.

Looking at the public as the audience of this message is, however, perhaps not quite so straightforward. Through articulating the problems in the profession, publicly shaming those structures involved in this loss of honour, and recommitting the profession to the service of the public, it seems, the TRC wished to restore public respect for health professionals. The loss of public respect resulting from the Biko case (and others) needed to be restored. The health profession was to be reinstated to its position as a noble profession in the public mind.

Is this however the image that the health sector wants to maintain in the public mind? It is perhaps instructive to look at the parallel process in the police services. The TRC hearings on the security forces did not go to any great lengths to pick out the bright spots in the actions of the police services. While the need for human rights training for police recruits, just like that of medical professionals, is highlighted by the TRC, the need for external monitoring and community empowerment is much more strongly emphasized. In part this is probably due to the much greater role played by the police in committing abuses, and the clear identification of the power imbalance between police and the community that provides the space for abuses.

It would however be seriously misguided to identify the cause of the problems in the health care profession as simply a lack of ethical commitment. Another ingredient is the balance of power - between doctor and patient or doctors and the public. A key aspect of the

solution to the health and human rights dilemma in South Africa is thus to empower patients and empower the public.

Various images presented at the hearing may be seen as being at odds with this broader empowerment agenda. Those making submissions to the hearing were overwhelmingly medical professionals themselves. Medical professionals were often the ones telling the stories on behalf of victims. This tone was set right from the start when Dr Folb presented the story of Steve Biko.¹³ When other victims presented their stories, their presentations were facilitated by health care professionals. The various cases of abuse were documented and presented by health care professionals. The voice of victims was thus largely absent in these accounts. Where people spoke of victims, the speakers were doctors. The schism that was addressed by these debates was thus mainly one of intra-professional division - between the ethical and unethical doctors - rather than that between the profession and the public.

If victim empowerment is a key aspect of the reconciliation agenda it would have to be their voices that are given credibility. In some ways, it seems that these voices have been co-opted by a faction of the health profession. While it is obviously commendable that doctors take on the needs and interests of the patients/victims, there is the danger that these voices may lose their independence.

This tension between human rights NGOs and their "constituency" of victims or the public is one that is common in South Africa. The health sector in South Africa is faced with the problem that there is no clear voice that can speak on behalf of victims. Doctor-patient relations are by their nature individualized. Victim representative groups are in their infancy and consumer rights structures are also underdeveloped and largely still driven by the wealthier white consumer society.

The use of victims' stories at the hearing was problematic. A key element of the TRC process was to give victims a voice, an opportunity to tell their stories. The purpose of this was (one would hope) not simply to collect information about abuses, or to enhance the emotional appeal of the message of reconciliation. The goal was to restore their dignity, to assist in their recovery and to empower them to speak out against future abuses.

The health sector hearing appears to have incorporated victims' stories only in a very limited manner. It seems that these stories were used to illustrate the broader patterns of abuse that had already been identified by the coordinators of the hearing. The hearing obviously had its limitations - it was not set up as a community hearing with space for a wide range of victims' stories. The victims' stories about their treatment at the hands of health professionals could not take up the whole two days. It may be argued that the hearing should be seen within the context of the preceding community hearings where victims spoke out all over the country. Looking at this two-phased approach as a model for storytelling, healing and reconciliation is however problematic. It means that the victims are used to give the process momentum, and the professionals are then brought into the process to come up with the solutions among themselves.

Only two participants interviewed seriously questioned the TRC's role in engaging and empowering victims:

The status quo of the powerful positions of the doctors in the society was perpetuated by the hearing. Victims will continue to be victims because they were not empowered by the hearings. They could only be empowered if they are part of the hearings. The power issues within different professions, e.g. client-professional, and gender issues, should be taken into consideration when transforming the whole medical set up. Massive education should also take place to teach the public their clinical rights so that they could guard it themselves. Otherwise the whole medical set up will be left unaccountable in various ways. (van Speyk, 1998)

The problem with health care is that it brings out the best in the liberal tradition of charity, which is not about empowerment at all. (Dassoo, 1999)

Another dimension of the empowerment challenge is the position of doctors vis-à-vis other professionals in the health care sector.

We must disempower the doctors. They have an inordinate amount of social and political power that they don't deserve and that they should not have. (Doctors) are not the cream of society that we are taught to believe. ... They trade on that naivety of public opinion about doctors. (Dassoo, 1998)

Another participant was also critical of the hearing's role in perpetuating the status quo regarding the position of doctors:

In my own view the doctors with their powerful positions in the sector dominated the entire hearing and that, in my opinion, only served to perpetuate the hierarchical situation of the past. (van Speyk, 1998)

This sentiment was also reflected in one of the submissions received by the TRC.

Certain individuals and institutions had been invited to make submission [to the Commission]. However, the rehabilitation therapists had not been included in this group, which consisted of doctors (and psychiatrists), nurses and psychologists. This seems to be a perpetuation of long-standing professional hierarchy/hegemony, which needs to be challenged as part of the health care sector hearings.¹⁴

Psychological Processes in Reconciliation

Another component of the reconciliation process that was not given sufficient space by the hearing was the opportunity to express anger, hurt and condemnation. In contrast with the cathartic victim hearings of the TRC, where victims got to tell their stories, the Health Sector Hearing focused on government and institutional policies of the past and moved from there to an examination of transformation processes. Rather than providing space for an emotional process of exposing the wounds and confronting perpetrators, the hearing engaged in a more formal intellectual exercise of analysis and assessment.

In part, this was a result of the hearing focusing on institutions rather than individuals.

While victims were not a central part of the hearing, neither were individual perpetrators. Part of the problem arose because individual perpetrators could not be named at the hearing, but more importantly, the intent of the hearing was also to concentrate on the role of institutions. The institution as perpetrator is not a satisfying focus of anger or condemnation. Accusations of racism and disrespect for human rights are also more easily deflected by institutions that can shift the blame to those who had previously held leadership positions. The anger that many victims and others have against racist institutions was delegitimized by the fact that these institutions were represented by new progressive appointees at the hearing. Victims and Commissioners could not rail against the Department of Health, MASA or medical schools for their role in discriminatory practices. The "perpetrator" institutions had already addressed the shortcomings of the past in a way that anticipated any criticisms and thus provided no scope for the expression of righteous indignation.

Especially where the focus of the hearing was on the need for further transformation, space for expressing anger about past behaviour was not adequately provided. This appears to have resulted in what seemed like inappropriate attacks on certain institutions that, some feel, were unwarranted. Some observers and participants criticized the Commissioners for not directing their strongest criticisms where they were most warranted, such as the SA Medical Services or the SAMDC, while subjecting groups like Wits Medical School and the Department of Health to excessive criticism. The real need for people who feel victimized to vent their anger is however not something that can be discounted.

This confusion about appropriate versus inappropriate targets of attack is, it appears, reflective of the multiple goals of the hearing. On the one hand, focussing on institutional transformation essentially requires an assessment of where things are now and where they still need to go. On the other hand, a reconciliation process must allow enough space to acknowledge that victims should be allowed to speak their mind. One cannot jump to the constructive forward-looking part of the program until people have had enough time to express their feelings about the past and have come to terms with what it meant. Providing a solution to the problems of the past, however good the solution, will not be accepted by victims or victimized groups unless a process of fully unearthing and dealing with that past precedes it. The hurry to move forward - to address institutional change without allowing sufficient time to listen to anger and hurt, could lead to the process being greeted with scepticism.

A process that attempts to compress these two agendas - the backward looking and the forward looking into too short a space of time is problematic. This is a lesson that MASA learned when it attempted to move ahead with its transformation without spelling out a process for engaging with its shady past. The same question can possibly also be asked of the Wits Health Faculty Internal Reconciliation Commission: Did it provide sufficient time and space for the negative aspects of the past to be revealed before seeking out the positive elements of its history and focussing its energies on transformation? Will those who feel they did not have enough of a voice in expressing their anger at their past victimization accept the integrity of the transformation process?

Putting Structural Violence on the Agenda

Every community needs its heroes to demonstrate and embody the values that are held dear.

The problem is that these individuals are not one-dimensional symbols. Nobody would deny the heroism of the acts of certain progressive doctors during apartheid. The problem arises when some are singled out above others. The selection criteria are then questioned, and the agenda set by this selection needs to be examined.

Another side of the debate about heroes is thus to ask: Heroes of which struggle are being honoured? The TRC hearing focussed on the heroes who opposed gross human rights violations, particularly the ones who fought for more humane treatment of detainees and prisoners. This definition leaves out the heroes who fought for the broader transformation of the health system in South Africa. There were those organizations and individuals who used the health sector as their battlefield for broader social justice. These heroes were not on the agenda of the hearing. Some would argue that, if national reconciliation was taken seriously, these are the heroes that need to be recognized.

The struggle against apartheid was not the struggle against gross human rights violations. The story of apartheid medicine is a story of lack of health services rather than one of abusive treatment by health professionals. On a broader level of public debate, the question of promoting national reconciliation in South Africa around questions of health is thus about reconciling those who did not have adequate health services with those who had. The grossly unequal provision of health services were so driven by racial categorization that their impact on racially determined life chances and racial divisions can not be left out of the reconciliation agenda.

As has been observed by various critics of the TRC, the dividing line in South Africa is mainly between beneficiaries of apartheid and victims of apartheid's structural violence. The nature of apartheid health care was a form of structural violence. It had beneficiaries and it had victims. From the perspective of the struggle for democracy, the most significant heroes to be honoured, it could be argued, are those who fought against the system as a whole.

This also raises the broader question of the agenda for transformation of the health sector. When looked at from the viewpoint of preventing gross human rights violations, the agenda is narrowly focussed on medical ethics, accountability, monitoring of professionals, etc. When looking at the structural abuses of apartheid health care, the agenda for transformation needs to be much broader. It then encompasses the extension of health services to black communities and rural areas, restructuring medical insurance, etc. For the TRC to focus narrowly on gross human rights violations can thus be interpreted as sidelining the agenda for deeper structural change. As one interviewee summarized the situation:

These medical schemes - with 7 million members - just in one year, 1998, they spent 25 billion Rand. The public service caters for the rest of our population of 33 million. The budget for them was 21 billion Rand. Balancing this scale is how you ensure a human rights culture in health care because here clearly is the human rights abuse. ... For a medical aid scheme member you are spending something like four thousand Rand per annum. For other you are spending R650. Look at the difference. Now if that is not an oppressive situation I don't know what is. (Dassoo, 1999)

Of course, this is not an either/or situation. The question of broader structural violence is addressed in the health sector hearing (probably more so than other hearings by the TRC). The hearing explicitly tried to engage with the question of broader aspects of human rights abuses, as one Commissioner explained:

Sectoral hearings were generally more flexible than other hearings. They allowed examination of more than just gross human rights violations. But ultimately we are still restricted by the TRC Act. We did try and interpret the mandate more broadly. The context and the atmosphere that shaped the environment for abuses to occur were thus seen as part of the mandate. Colluding with the system of apartheid is a central aspect of this context. (Wildschutt, 1998)

It is however a matter of prioritisation and weighting of different components of past abuses and future transformation. One critic of the TRC hearing argued, for example, that the hearing could have been used to raise public awareness of the continued inequalities in health care in South Africa:

The TRC should have focussed on events that were critical in revealing the facts about the struggle against apartheid health care. There were key horrific events such as the closure of facilities, local municipalities that closed down clean water supplies to poor communities, and police entering the casualty wards of Baragwanath Hospital to kill injured protestors. These events (and many others) and the efforts by health care workers to fight for the provision of better health care to poor communities are more important than the individual cases of doctors taking legal action against the state. The health sector hearing presented a certain liberal mind set for understanding the abuses under apartheid that is at odds with my experience in the struggle. (Dassoo, 1998)

Dr Dassoo argues that the hearing could have contributed to greater public consensus around the need for a radical transformation of our health services if handled properly. The bigger struggle to make health care available to the poorer sectors of society could thus have been facilitated, but this opportunity was lost.

One area where the hearing did appear to pay a lot of attention to the issue of racial inequalities was that of the medical schools and their policies of racial discrimination. The medical education system built around apartheid health where clearly characterized by discrimination. White health care professionals are the beneficiaries of this system and blacks are the victims. Black medical students and blacks that were denied the opportunity to become medical students were victimized.

This focus does however make sense when viewed in the context of the focus on professional rehabilitation. A key aspect of the rehabilitative process is to address the racial divisions within the health care sector. Overcoming the past racial differences in this sense is however not reflective of broader social reconciliation. It can be viewed as a form of elite reconciliation. The focus is on building solidarity among those who are privileged. If one sees the present divisions in society as between the haves and the have-nots, this focus on building stronger relationships within the health sector can be viewed with some scepticism as simply confirming the narrower liberal agenda of the hearing.

The recommendations of the report were also seen by some critics as containing a liberal bias in that it emphasizes the principles of transparency and confidentiality.

I would, instead, have gone for (a recommendation which states that) present health care legislation be reviewed to ensure accessibility, affordability, equity, accountability and transparency. (Dassoo, 1999)

Conclusions

The TRC's engagement with the Health Sector was a unique intervention in the history of truth commissions. It was not something that was anticipated by those who conceptualised and legislated the act that established the TRC. As a novel way to address institutional complicity in human rights abuses and promoting a human rights agenda, it proved to be a valuable exercise. Most participants saw it as a useful intervention, while those who criticized it, still believed the hearing was as the right thing to do.

The one key problem faced by the convenors of the hearing was that there were no clear objectives and procedures for sectoral hearings. There was thus no unanimity about the objectives or the correct procedures to be followed. The process of engaging stakeholders thus became, understandably, subject to controversy. The agenda of the hearing itself, because of its potential role in recasting history and setting a transformation agenda was also hotly contested.

The lack of engagement by key stakeholders with the Final Report underscores the importance of the Hearing as a process, rather than a policy development body. The TRC was established more as a facilitating body, rather than one tasked with investigating and recording details of abuses. It was also not conceptualised in a way that would maximize its capacity to develop detailed recommendations and implementation strategies.

The significance of the TRC's intervention was more as a catalyst in engaging parties in a process of accounting, dialogue and public education. While there are positive signs of change in this regard, the hearing can mainly be seen as a further impetus to initiatives that were already underway, rather than a completely new incentive or vital transforming moment in the transformation process.

Notes:

¹ This paper is based on interviews with stakeholders in the health sector and from the TRC, an examination of the transcripts of the Health Sector Hearing, and a review of the newspaper coverage of the Hearing. Some of the interviews were conducted by Lazarus Kgalema who also made comments on initial drafts of the paper.

² See for example:

Hamber, B., Maepa, T., Mofokeng, T. and van der Merwe, H. (1988) "[Submission to the TRC: Survivors' Perceptions of the TRC and Suggestions for the Final Report](#)," Centre for the Study of Violence and Reconciliation.

van der Merwe, H. Dewhirst P.H. and Hamber, B. (1999) "[Non-Governmental Organisations and the Truth and Reconciliation Commission: An Impact Assessment](#)",

Politikon, 26(1), May, pp. 55-79.

van der Merwe, H. (1999) "Community Reconciliation in South Africa: Lessons from the TRC's Intervention in Two Communities", in Abu-Nimer, Mohammed (ed.) *Promoting Justice and Peace through Reconciliation and Coexistence Alternatives*, Roman & Littlefield.

van der Merwe, H. (1999) "[Some Insights from a Case Study of Duduza](#)" published as section of TRC Final Report Chapter on Reconciliation, Vol. 5, Chapter 9, pp. 423-429.

van der Merwe, H. and Kgalema, L. "[The Truth and Reconciliation Commission: A Foundation for Community Reconciliation?](#)" *Reconciliation International*, June, 1998

Hamber, B. (1997) "The Burdens of Truth: An evaluation of the Psychological Support Services and initiatives undertaken by the South African Truth and Reconciliation Commission," *American Imago*, Vol. 55, No. 1.

³ A number of participants in the conference, including the TRC Commissioner who co-ordinated the health sector hearing, wrote to the South African Medical Journal to appeal to MASA to support the establishment of a TRC for the medical profession.

⁴ See Orr, W. (1997) "The South African Truth and Reconciliation Commission – What Role has it Played in Bringing about Transformation in the Health Care Sector," Address for the 8th International Congress of the World Federation of Public Health Associations, 8 October.

⁵ [The Promotion of National Unity and Reconciliation Act of 1995](#), Section 3 (1) (a)

⁶ The full transcript of the two days of hearings is available on the TRC website: <http://www.doj.gov.za/trc/index.html>

⁷ The Broederbond was a secretive organisation of Afrikaners that influenced key appointments in the public sector.

⁸ For a more detailed analysis of the TRC's approach to reconciliation see Hamber, B. and van der Merwe, H. (1998) "[What is this thing called reconciliation?](#)" in *Reconciliation Update*, CSVR, April.

⁹ The only dramatic exception was the TRC's investigation into the chemical weapons programme that was conducted under authorisation of the South African Medical Services.

¹⁰ Among the nursing profession there was also the belief that individuals should be given professional amnesty if they did provide voluntary disclosure about misconduct.

The Nursing Council has an amnesty. We as DENOSA challenged the Nursing Council to give an amnesty to any nurses who gave full and voluntary disclosure to the TRC. You can take that in 2 ways – you can say if they did so, why do they get off "scott free;" but from a professional point of view, we wanted to try and put it in place so that nurses would come forward. That was on our recommendation, and the Nursing Council did do that. (Clow, 1999)

¹¹ The Surgeon General, Dr Knobel, was found, amongst other things, to be grossly negligent in approving chemical warfare programmes, to be aware of the production of murder weapons by people under his command, to have approved budgets for research on weapons (including Cholera, fertility drugs, mandrax and ecstasy) targeted at eliminating whole communities.

¹² One interviewee was particularly upset about the way that the hearing appeared to become "a personal aggrandizement" event in honor of individual doctors.

¹³ Steve Biko was a prominent black leader who was tortured and killed by the police. The complicity of doctors in this incident led to an international outcry and a crisis within the health care profession in South Africa.

¹⁴ Combined submission by physiotherapy professional group to the TRC – quoted in the TRC Final Report, Vol. 4, Chapter 5, p. 143

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