MEDICAL PROFESSIONALS IN ARMED CONFLICT:

THE CASE OF DR WOUTER BASSON

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SUMMARY

The thesis investigates the place and role of medical professionals in armed conflict and focuses specifically on the case in South Africa of Dr Wouter Basson. The thesis traces the role of medical professionals in armed conflict from early Roman civilisations until after World War II, and outlines medical health service in South Africa after World War II.

The ethical and legal obligations of medical professionals during armed conflict are discussed, together with a brief overview of the Nuremberg Doctor's Trial. This is done in order to highlight the international legal and ethical frameworks within which medical professionals operate in situations of armed conflict.

Dr Wouter Basson and Project Coast are selected to serve as a case study. The circumstances under which Dr Basson operated as well as the national and international law elements of Project Coast are canvassed. Dr Basson's criminal trial, his subsequent appeals as well as his disciplinary hearing before the Health Professions Council of South Africa are scrutinised. South African constitutional law, as well as the HPCSA's Guidelines for Good Practice in the Health Care Professions as they apply to the case study are examined. The thesis concludes by offering answers to the research questions and proposing a number of recommendations.

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CHAPTER 1

INTRODUCTION

1.1 Background

The world has seen many an armed conflict during the past century. The twentieth century commenced with the political entities in South Africa engaged in a war between the British Empire and the Boer Republics.[1] The South African war was followed by the Great War or First World War (WWI) in July 1914 and ending in November 1918, in which millions became entangled in the conflict to decide who should dominate Europe.[2] The Second World War II (WWII) began in 1939, still more millions were dragged into a conflict initiated by the German Chancellor, Adolf Hitler, and suffered the atrocities committed under National Socialism.[3] Conflicts on a smaller scale followed; the Korean War (1950 – 1953)[4] and the Vietnam War (Second Indochina War) (1955 – 1975),[5] as well as numerous others including civil wars and the Cold War that continued until 1989.

In 1966 South Africa saw the start of a war on the border between South-West Africa (SWA) (now Namibia) and Angola, one of the many proxy wars fought in the twentieth century. After WWI the Union of South Africa administered SWA under mandate following the departure of the German forces from the colony. Under the Treaty of Versailles[6] SWA was declared a League of Nations Mandate Territory.[7] The 1960s saw a world-wide conflict between the Soviet Union and a Western alliance under the leadership of the United States of America known as the Cold War.

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1 Schmidt, EA "The Anglo-Boer War in a century of peace" (2007) 52 *Historia* 155 – 171, available at http://www.sahistory.org.za/article/second-anglo-boer-war-1899-1902 (accessed on 21 July 2015).

2 "Armistice Day/Poppy Day: World War One feature" (2014) 10 *Without prejudice* 50 – 51, available at http://www.history.com/topics/world-war-i/world-war-i-history (accessed on 21 July 2015).

3 Available at http://www.history.co.uk/study-topics/history-of-ww2 (accessed on 21 July 2015).

4 Borch, FL "The cease-fire on the Korean Peninsula: the story of the Judge Advocate who drafted the armistice agreement that ended the Korean War" 8 (2013) *Army lawyer* 1 – 3.

5 Herring, CG "America and Vietnam: the unending war*"* (1991) 70.5 *Foreign affairs* 104 – 119. Also available at http://www.historynet.com/vietnam-war and http://thevietnamwar.info/ (accessed on 21 July 2015).

6 Dugard, J *International law: A South African perspective* (2013) 17.

7 *Ibid*.

The South African government increasingly became engaged in an armed conflict with a liberation movement in SWA, the South-West African People's Organisation (SWAPO), which was demanding independence. In its revolt against the apartheid system SWAPO sought support in the international community, particularly from the Soviet Union and its proxy, Cuba.[8] The communist-supported insurgency in SWA led to the South African government taking military action. South Africa's conscript armed forces were sent to provide military support against SWAPO on the SWA–Angola border.[9] The South African government declared the indigenous opponents terrorists.

The war on South West Africa's border lasted for 23 years. This conflict saw a young medical doctor, Wouter Basson, start his military career. Dr Basson joined the SADF in 1979 as a medical officer in the South African Medical Services,[10] and those in command soon recognised his leadership potential and intellect.[11] Within two years Dr Basson had qualified as an internal medicine specialist and served as a specialist advisor at Defence Headquarters.[12] Dr Basson's knowledge of biochemistry and medicine made him the ideal candidate to head the chemical and biological weapons research and development programme of the SADF called Project Coast. Basson soon was promoted to Project Officer for Project Coast.[13] In 1985 Dr Basson was promoted to the rank of colonel and in 1988 became a brigadier-general and head of Medical Staff Operations.[14] His rapid rise in the military ranks was unprecedented and with every project he became more influential and powerful.[15]

South Africa's military withdrawal and Namibian independence were followed by majority democratic elections in South Africa. Dr Basson left the military for private practice, and subsequently was criminally charged in the High Court for his involvement

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8 Geldenhuys, JJ *Ons was daar - wenners van die oorlog om Suider-Afrika* (2011) 45 – 50; see also https://sites.google.com/site/sabushwarsite/overview (accessed on 21 July 2015).

9 *Ibid*.

10 Hereafter "SAMS".

11 Gould, C & Fold, P *Project Coast: Apartheid's chemical and biological warfare programme* (2002) United Nations institute for disarmament research, United Nations 43.

12 *Ibid.*

13 *Ibid.*

14 *Ibid.*

15 *Ibid.*

in Project Coast.[16] During the criminal trial in 2000 Dr Basson disputed his alleged involvement in various chemical and/or biological operations,[17] and was cleared of all charges. Dr Basson subsequently qualified as a cardiologist and continues to practice in the Western Cape.

In 2007 disciplinary proceedings were instituted against Dr Basson at the Health Professionals Council of South Africa. In December 2013 Dr Basson was found guilty on four charges of unprofessional and unethical conduct. At the time of drafting this thesis no sanction has yet been imposed on Dr Basson.[18]

Dr Basson's career is an example of the manner in which a medical professional becomes involved in projects of a military nature, but whose skills are of great value. These events have been related to the infamous Pernkopff Anatomy Atlas, but Dr Basson was not involved in mass atrocities, nor did his work rely on findings gained by such atrocities.[19]

Dr Basson's research while in the military raises the question as to the nature of the oversight that was exercised, indicating a blind eye was turned to his activities and he had *carte blanche*. An inference is that the authorities were aware but justified this behaviour as 'being in the interest of national security'. The question this situation poses is whether medical ethics in war differ from medical ethics in times of peace or, put differently, whether medical practitioners are held to a different standard during times of war than in peacetime.

A situation of a similar nature presented itself in the early 2000s involving the United States of America (USA or US). After the events of September 11 the US government declared a 'war on terror', in particular against Al-Qaida,[20] which the US

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16 *S v Wouter Basson* CC32/99 (TPD) (unreported).

17 *Ibid*.

18 https://www.timeslive.co.za/news/south-africa/2018-01-17-basson-wins-challenge-on-professors-deciding-his-sentence-for-misconduct/ (accessed on 21 July 2015).

19 Carstens, P "Revisiting the infamous Pernkopf anatomy atlas: historical lessons for medical law and ethics" (2012) 18(2) *Fundamina* 23 - 49.

20 http://news.bbc.co.uk/onthisday/hi/dates/stories/september/12/newsid_2515000/2515239.stm (accessed on 21 July 2015).

labelled a non-international armed conflict (NIAC).[21] A number of combatants were detained in the Guantanamo Bay prison on the island of Cuba[22] from 2002 onwards.[23]

The unwillingness of the prisoners and the failure of interrogation techniques to deliver results[24] led the Department of Defence to propose that their psychological and medical experts develop new interrogation techniques.[25] The President, George W Bush, approved the programme and hundreds of suspected terrorists have been interrogated using these techniques.[26] In this case the government sanctioned these programmes and turned a blind eye to any infringements committed.[27]

The actions of US medical professionals in armed conflict have received international attention and have prompted accusations of widespread human rights violations. Various non-governmental organisations (NGOs) have condemned the actions of the US government and demand that these practices be stopped immediately.[28] Public condemnation has put pressure on the US government to desist from such practices.[29]

The behaviour of medical professionals in the two instances mentioned above on the face of it is an obvious breach of the rules of professional and ethical conduct and

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21 http://www.ejiltalk.org/obamas-counter-terrorism-speech-a-turning-point-or-more-of-the-same/ (accessed on 21 July 2015). The classification of an armed conflict as either an international or non-international armed conflict has implications for the protections offered to combatants and non-combatants alike. See Research question 3.3 below.

22 http://www.aljazeera.com/indepth/features/2016/01/released-guantanamo-bay-detainees-160110094618370.html (accessed on 21 July 2015).

23 Guiora, A & Page, E "The unholy trinity: Intelligence, interrogation and torture," (2005-2006) 37 *Case western reserve journal of international law* 427 - 448. http://edition.cnn.com/2013/09/09/world/guantanamo-bay-naval-station-fast-facts/ (accessed on 21 July 2015).

24 Meriwether, L "After Abu Ghraib: does the McCain Amendment, as part of the 2006 Defense Appropriations Act, clarify U.S. interrogation policy or tie the hands of U.S. interrogators" (2006) 14(1) *Tulsa journal of comparative & international law* 155 - 190.

25 Freer, R “Turning to torture in a ‘nation of law’ torture team: deception, cruelty and the compromise of law” (2009) 1(1) *Journal of human rights practice* 168 – 179.

26 http://www.theguardian.com/us-news/2014/dec/09/cia-torture-methods-waterboarding-sleep-deprivation (accessed on 21 July 2015). https://www.theguardian.com/us-news/ng-interactive/2017/oct/09/cia-torture-black-site-enhanced-interrogation (accessed on 21 July 2015).

27 Gould & Fold (n 11 above) vii.

28 http://www.independent.co.uk/news/world/americas/obama-orders-cia-to-stop-torturing-terror-suspects-1513428.html (accessed on 21 July 2015).

29 https://www.whitehouse.gov/the_press_office/EnsuringLawfulInterrogations (accessed on 21 July 2015).

those who are involved must be brought to book. This fact raises a question whether current international and municipal law allow for the arrest and trial of individuals involved in these practices. This question requires a thorough investigation in terms of the law and recommendations made in this regard.

Armed conflict of necessity involves medical professionals. For this reason what constitutes unprofessional conduct in this context must be investigated in order to determine the steps to be taken to rectify the harm caused and reach a decision whether those involved in misconduct are allowed to return to private practice.

1.2 Problem statement

A foundational principle in international humanitarian law (IHL) is that it applies to all persons involved in an armed conflict, including the armed forces and the civilian population.[30] During an armed conflict in correspondence with the rules of the 1949 Geneva Conventions[31] and their various Additional Protocols and as long as the nature

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30 Dugard (n 6 above) 519; art 41(2) Protocol additional to the Geneva Conventions of 12 August 1949, and relating to the protection of victims of international armed conflicts, June 8, 1977, 1125 UNTS 3 (AP I); Schmitt, MN "Targeting in operational law" in *The handbook of the international law of military operations* (2010) 268.

31 Geneva Conventions I – IV (12 August 1949):

Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field	Aug. 12, 1949	75 UNTS 31
Geneva Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea	Aug. 12, 1949	75 UNTS 85
Geneva Convention Relative to the Treatment of Prisoners of War	Aug. 12, 1949	75 UNTS 135
Geneva Convention Relative to the Protection of Civilian Persons in Times of War	Aug. 12, 1949	75 UNTS 287
Protocol Additions to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts	June 8, 1977	1125 UNTS 3
Protocol II Additional to the Geneva Conventions of 12 August 1949 and Relating to the Protection of Victims of Non-International Armed Conflicts	June 8, 1977	1125 UNTS 609
Protocol III Additional to the Geneva Conventions of 12 August 1949, *and Relating to the Adoption of an Additional Distinctive Emblem.*	Dec. 8, 2005	

of the armed conflict fits the confines of the different IHL Conventions, the harm inflicted on soldiers is deemed justifiable.[32]

The wounded and sick combatants of warring parties are considered *hors de combat* (out of the battle) and are protected and cared for, irrespective of on which side they are fighting. The rules of IHL govern the medical treatment of wounded persons, including members of the armed forces as well as civilians.[33] Medical personnel serve near the site of an armed conflict and at all times are bound by IHL rules. Furthermore, medical personnel must adhere to the principle of medical neutrality during an armed conflict.[34]

The rules of IHL prohibit the use of certain weapons, for instance, the Convention on the Prohibition of the Development, Production, Stockpiling, and use of Chemical Weapons and on their Destruction,[35] the Convention on the Prohibition of the Development, Production, and Stockpiling of Bacteriological and Toxin Weapons,[36] and the Convention on Prohibition or Restrictions on the Use of Certain Conventional Weapons which may be deemed to be Excessively Injurious or have Indiscriminate Effects.[37] These conventions all prohibit the development, production, stockpiling and use of such weapons. Contravention of these conventions can lead to criminal

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32 https://www.icrc.org/eng/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-conventions.htm (accessed on 21 July 2015).

33 *Ibid.*

34 Preamble, Statutes of the International Red Cross and Red Crescent Movement (adopted by the 25th International Conference of the Red Cross at Geneva in 1986). See also, eg, Katari, R S "Medical neutrality and solidarity in the Syrian armed conflict" (2013) 1 *The journal of global health* 28; and Hathout, L "The right to practice medicine without repercussions: ethical issues in times of political strife" (2012) 7 *Philosophy, ethics, and humanities in medicine* 11.

35 The Convention on the prohibition of the development, production, stockpiling and use of chemical weapons and on their destruction (29 April 1997) 1974 UNTS 45; 32 ILM 800 (1993); "Chemical Weapons Convention".

36 The Convention on the prohibition of the development, production, and stockpiling of bacteriological and toxin weapons 1015 UNTS 163; 11 ILM 309 (1972) (26 March 1975); "Biological Weapons Convention".

37 The Convention on the prohibition or restrictions on the use of certain conventional weapons which may be deemed to be excessively injurious or have indiscriminate effects (10 October 1980) 1342 UNTS 137 (1983); the "Conventional Weapons Convention".

prosecution under national laws and, in addition, are deemed a contravention of the Statute of the International Criminal Court (ICC Statute).[38]

In consequence, there is a reflection on the responsibility of a health care professional in military service and in contravention of international humanitarian law as set out in these conventions. Dr Wouter Basson, the former military surgeon and Head of 7 Medical Battalion of the South African Military Health Service, presents an example of a medical professional who allegedly is involved with the manufacturing of chemical and biological weapons in contravention of the rules of IHL.

Dr Basson is not alone in the accusation of involvement in acts in contravention of IHL. The torture of prisoners (alleged terrorists) by the United States of America (USA) in detention in various prisons and holding facilities worldwide has been publicised, as mentioned above.[39] Allegedly, medical professionals helped to coordinate these torture programmes and, to some extent, enforce them.[40] The USA is not a party to the Rome Statute, although they are a party to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[41] As a result, the ICC cannot charge American citizens for acts committed on the territory of a non-signatory state, such as Iraq.[42]

The nature of the involvement of medical professionals in armed conflict is as much a practical as it is an ethical problem. Their ethical responsibility as health care professionals needs to be reconciled with their actions during an armed conflict. In addition, there is a question as to whether medical professionals who commit contraventions of IHL should be allowed back into civilian medical practice taking into consideration the potential contribution they may make. There is a need to socially

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38 UN General Assembly, Statute of the International Criminal Court (last amended 2010), 17 July 1998, ISBN No. 92-9227-227-6; hereafter “Rome Statute”. In terms of art 8 of the ICC Statute, the use of these weapons will cause superfluous injury and cannot be directed solely at combatants. Civilians will suffer as a result of the use thereof, and therefore criminal prosecution by the ICC is warranted.

39 http://www.reuters.com/article/2015/06/02/us-usa-torture-khan-idUSKBN0OI1TW20150602#Z1CyHBbqBvOApDl0.97 (accessed on 21 July 2015).

40 *Ibid.*

41 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 26 July 1987, 1465 UNTS 85. Hereafter “the Torture Convention”.

42 Art 12 of the ICC Statute.

justify their subsequent involvement in healthcare based purely on professional skill in ignorance of their breach of the ethics of their profession during military operations.

1.3 Assumptions

1.3.1 International humanitarian law protects all parties involved in armed conflict.

1.3.2 The production of chemical and biological weapons *prima facie* contravenes international and municipal law.

1.3.3 The duties of physicians as stated in the World Medical Association International Code of Ethics[43] apply to the actions of military physicians.

1.3.4 Medical personnel must adhere to the principle of medical neutrality at all times in armed conflict.

1.3.5 Individual participation in a state operation is as much a crime as is state participation.

1.3.6 During trials of war criminals, "obeying orders" is not an acceptable defence. In other words, an accused cannot defend his actions by alleging that he was reasonably forced or ordered to commit such atrocities although aware that such an act is in violation of international law.

1.4 Research questions

1.4.1 Are there specific international or South African medical ethical rules prohibiting medical professionals from conducting research into or assisting in the manufacturing of biological or chemical weapons for military purposes? What are these ethical rules and which sanctions may be imposed on a perpetrator who violates these rules and/or laws?

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[43] Medical Association International code of medical ethics (1949 1(3)) *World Medical Association Bulletin* 109 - 111. Their actions are specifically covered by the WMA Regulations in Times of Armed Conflict and Other Situations of Violence, which state: "Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics."

1.4.2 Are there ethical or legal justifications for research into biological/chemical weapons?[44]

1.4.3 In these circumstances are their actions to be viewed from the standpoint of medical professionals or as soldiers or both?

1.4.4 Should medical professionals who are accused of alleged unethical conduct during military service at a later date be allowed to practice medicine in the civilian health sector? What are the arguments for and against their involvement in the civilian health sector?

1.5 Methodology

I followed a desktop-based research methodology consisting of a historical analysis of the role of medical professionals in armed conflict, as well as recounting the atrocities committed during the past century that involved medical professionals in order to focus on the career of Dr Basson.

The historical background to Project Coast is presented alongside the events which prompted the US government to implement the contested interrogation programme. The aim is critically to investigate the conduct in both circumstances.

The investigation is comparative in form with particular reference to international law conventions and ethical codes of conduct. Central to the discussion is reference to the Constitution, 1996, as the South African context is foundational to the thesis. The main focus is the interpretation of the regulations and implementation of international treaties and municipal law, and on the constitutional obligations these bestow on the South African (and others) government in this regard. At this juncture it is noted that the

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[44] In this regard, see Gross, ML *Bioethics and armed conflict: moral dilemmas of medicine and war* (2006): Gross argues, eg, that physicians' participation in torture is permissible if necessary to prevent imminent harm. According to Gross, physicians may have a duty to participate in weapons development.

scope of this study is limited due to the unavailability of certain information pertaining to Basson's disciplinary hearings.

1.6 Chapter outline

The thesis is structured as follows:

Chapter 1: Introduction

Chapter 2: Historical analysis of the place and role of medical professionals in armed conflict

Chapter 3: Ethical and legal obligations of medical professionals during war: International law and medical ethics

Chapter 4: A case study of Dr Wouter Basson and Project Coast

Chapter 5: Medical professionals in South Africa: Dr Basson and municipal law

Chapter 6: Recommendations and conclusions

In order to establish a context for Dr Basson's conduct, a foundation from which the investigation is conducted is laid in chapter 2 in which the place and role of medical professionals in armed conflict are discussed.

CHAPTER 2

HISTORICAL ANALYSIS OF THE PLACE AND ROLE OF MEDICAL PROFESSIONALS IN ARMED CONFLICT

2.1 Introduction

The purpose in this chapter is to provide a historical analysis of the origin of the rules regarding the conduct of medical personnel in armed conflict and how their role has changed over the course of history. The motivation is that gaining an understanding of their evolving role and of what is required of medical personnel in conflict situations will enlighten the circumstances under which medical personnel, such as Dr Basson, function and will provide a context in relation to their objectives and subsequent conduct.

2.2 Early Roman civilisation and medical personnel

If armed conflict has always existed,[1] then medical professionals in one form or another were present during these conflicts, albeit in a primitive form and an informal fashion.[2]

The Roman army in ways similar to modern armed forces offered a considerable opportunity for medical personnel to improve their skills as well as to raise the standard of health care provided to the wounded.[3] The exposure to the injuries inflicted in battle gave surgeons a better understanding of anatomy and physiology than they might have obtained in civilian private practice.[4] The military medical health care division of an army ought to be as impressively professional as its fighting forces; medics accompany infantry platoons on patrol and have to be able in poor circumstances to provide primary

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1 Genesis 14:1-24.

2 Joyce, PW *Social history of ancient Ireland: treating of the government, military system, and law; religion, learning, and art; trades, industries, and commerce; manners, customs, and domestic life, of the ancient Irish people* (1903) 599.

3 Jackson, R *Doctors and diseases in the Roman Empire* (1988) 112 – 137.

4 *Ibid.*

care to a wounded combatant, often under fire, and to risk their own lives to care for the wounded.[5]

A systemic form of army medical services dates back to the late first century BC and early first century AD when the Emperor Augustus took command of the Roman forces and introduced a series of sweeping changes, which established a professional standing army and, for the time, an impressive military health care system.[6] As a result of Augustus' organisational skills and through constant training the Roman army became the most efficient (and expensive) army in the world.[7] Viewed as a precious asset, the health and well-being of the army was a priority and the focus not only on reactive but on preventive treatment.[8]

Disease was rife in the armed forces and its effect devastating. In the Parthian war of 35 BC Mark Anthony lost half his fighting force through illness to the satisfaction of the victor, Augustus.[9] Medical professionals examined candidate soldiers and by putting them through a series of rigorous tests hoped to ensure that only the best were selected.[10]

Roman military medical professionals were of the opinion that as well as a nutritious diet physical exercise was a benefit in preventing illness.[11] Strict regulations were issued regarding water and sanitation to curb contamination of drinking water sources in order to alleviate the risk of dysenteric disease.[12] In the event of illness or injury on the battlefield soldiers received attention from their platoon medic or *capsarii* (named after the bandage box they carried, *capsa*). If a soldier was fortunate enough to

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5 *Ibid.*

6 *Ibid.*

7 *Ibid.*

8 *Ibid.* Prevention of illness was cardinal as a simple outbreak of food poisoning could effect devastating losses in the legions and result in the loss of a battle and of territory.

9 *Ibid.*

10 *Ibid.* In a text dating from the fourth century AD a candidate soldier was discharged by a panel of three doctors in Alexandria as a result of having a cataract.

11 *Ibid.*

12 *Ibid.*

survive to make it back to the field hospital or fort, he would be given medical attention by the senior doctor or *medicus*, including surgery.[13]

A renowned medical facility in the Roman Empire was *Cohors IV Praetoria* which employed two famous doctors, Caius Terentius Symphorus, a surgeon or *medicus chirurgus*, and Tiberius Claudius Iulianus, an internist or *medicus clinicus*.[14] In areas where snake bites or scorpion stings were prevalent a *marsus* administered treatment.[15] However, the ordinary military doctor or *medici* was expected to have knowledge of and to treat a spectrum of conditions. Senior doctors were awarded a rank similar to those of senior military officers.[16]

Military doctors provided medical assistance not only to the soldiers but also to the community.[17] Although systemically the military health service was sound, the treatment administered was primitive and not very effective. Treatment mostly was based on medicinal plants and herbs with up to 600 remedies noted in a series of books by Dioscorides called *De Materia Medica*.[18] The medical corps was skilled in designing new medical instruments as required such as forceps, hooks and dilators; although these often proved inefficient as a result of a lack of knowledge *inter alia* of human anatomy.[19]

2.3 The Renaissance

During the period known as the Renaissance significant strides were made in medical treatment as the sources of medical information became available and the universities again performed dissections.[20] Leonardo Da Vinci's contribution to medicine is through

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13 *Ibid.*
14 *Ibid.*
15 *Ibid.*
16 *Ibid.*
17 *Ibid.*
18 Sutcliffe, J & Duins, N *A history of medicine* (1992) 21.
19 *Ibid.* Also see Jackson 114.
20 *Idem* 34.

his accurate anatomical drawings, such as the position of the foetus within the uterus.[21] His drawings were lost for almost 300 years after his death and had they been widely available military doctors among others would have gained much from his studies.[22]

Surgery made major advances as a result of the work of experienced surgeons, such as John Arderne. He served during the Hundred Years' War and had invaluable experience in treating gaping wounds often filled with dirt the result of sword injuries as well as the bullets of newly-developed guns.[23] Because these wounds often became septic, doctors assumed that the weapons contained poison. They sought to combat septicaemia by pouring boiling oil onto the wound, which also reduced bleeding.[24]

In the 16th century Ambroise Paré discovered a ligature procedure which made amputation more successful.[25] This was a considerable advance for surgery, and the connection between medicine and science that was beginning led to the important discoveries of 19th century medicine.[26] The role military doctors played as a result of their experience of armed conflict indicates their value to an investigation of the foundations of military health care.

2.4 Rules of war and the wounded

During the period of 'classical' warfare[27], from 1700 to 1870, the rules of war were established and the foundation was laid for the development of international

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21 *Ibid.*

22 *Ibid.*

23 *Ibid.*

24 *Ibid.*

25 *Idem 35.*

26 *Ibid.*

27 A formal battlefield was agreed upon between the parties, whereupon uniformed soldiers would line up against one another in open confrontation and fire at the enemy in a well-organized linear formation. After the linear formations were almost completely wiped out, a free for all 'battle royal' would ensue.

humanitarian law.[28] In this period the battlefield was identified in advance and the parties agreed to a date on which hostilities would commence.

The parties approved clear rules which were to be adhered to;[29] for instance a prohibition on the poisoning of water-wells and the execution of prisoners of war.[30] These were considered resources valuable to both parties as at a later stage they could be utilised to their own advantage. These rules, however, were based upon custom or tradition and were only temporary or applied locally.[31] Battles commenced at dawn, the armies met on an open field and were lined up in formation in clear sight of the enemy. Usually by dusk the outcome was clear with one party the victor.[32]

In this period a turning point was reached in the development of international humanitarian law. During the battle of Solferino in 1859[33] the 'founder' of the International Committee of the Red Cross, Henry Dunant, was witness to the suffering of the sick and wounded.[34] Realising medical assistance was lacking, Dunant gathered local villagers to aid the sick and wounded.[35]

In 1862 during the American Civil War a German-born professor of law, Dr Francis Lieber, witnessed the carnage and suffering at first hand.[36] He had three sons engaged in the war; two fought for the Union and one died fighting on the Confederate side.[37] In an effort to address the suffering and lackadaisical treatment of slaves, prisoners of war and wounded soldiers, Lieber suggested to the attorney-general that the president issue a codified procedure to the army with regard to their treatment.[38] By

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28 Whitman JQ 'Verdict of battle: modern war and humanitarian law' 13(3) (2013) *Insights on law and society* 20 – 24.

29 *Ibid*.

30 https://ihl-databases.icrc.org/customary-ihl/eng/docs/v2_rul_rule72 (20 March 2017)

31 https://www.icrc.org/eng/war-and-law/overview-war-and-law.htm (accessed on 20 March 2017).

32 Whitman (n 72 above) 20.

33 Murdock, H & Fiske, J *The reconstruction of a sketch of the diplomatic and military history of Continental Europe from the rise to the fall of the second French Empire* (1890) 137 – 155.

34 Whitman 20.

35 https://www.icrc.org/eng/war-and-law/overview-war-and-law.htm (accessed on 20 March 2017).

36 Paust, J 'Dr Francis Lieber and the Lieber Code' 95 (2001) *American society of international law proceedings* 112 – 114.

37 *Ibid.*

38 *Ibid.*

1863, after various amendments, General Orders No 100 was signed by President Lincoln and issued to Union soldiers.[39] General Orders No 100 later was known as the Lieber Code, and was influential in similar codes being issued by European countries such as Britain and France.[40]

As a direct result of the efforts by Dunant and Lieber a central element in the Geneva Conventions[41] took shape; the humane treatment of those no longer part of the battle.[42] Subsequently, the first Geneva Convention was signed by 16 countries in 1864,[43] initiating international humanitarian law and its enforcement that is on-going.[44] Arguably, many countries that were initial signatories of the 1864 Convention did not strictly implement the obligations imposed upon them in the Convention.[45]

2.5 Southern Africa and military medicine

The second South African war (ABW) introduces a southern African role. It is described as a 'transitional' war in which there were radical changes to warfare and advances in medical treatment.[46] By any standard the consequences of war were devastating; thousands of wounded were left to the ministrations of poorly-equipped field ambulances.[47] The Zuid-Afrikaansche Republiek (ZAR) became a signatory to the Geneva Convention in 1896,[48] which meant that its forces were bound by the

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39 *Ibid.*

40 Paust 112 – 114.

41 Geneva Conventions I – IV (12 August 1949) (see Ch 1 n 31 for citations).

42 Paust 112 – 114.

43 Geneva Convention I: Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva Convention II: Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces at Sea. Geneva Convention III: Geneva Convention Relative to the Treatment of Prisoners of War. Geneva Convention IV: Geneva Convention Relative to the Protection of Civilian Persons in Times of War (see Ch 1 n 31 for citations).

44 https://www.icrc.org/eng/war-and-law/overview-war-and-law.htm (accessed on 20 March 2017).

45 Paust 112 – 114.

46 De Villiers, JC 'The medical aspect of the Anglo Boer War 1899-1902: Part 1' 6(2) (1983) *Military history journal*. Available at http://samilitaryhistory.org/vol062jc.html (accessed on 20 March 2017).

47 *Ibid*.

48 *Ibid.*

obligations and responsibilities of the convention. At this time the first Red Cross unit was established in Pretoria.

Medical assistance was scarce among the Boer forces and a request for volunteers to serve in the Transvaal Red Cross was advertised.[49] The response was overwhelming but disorganised causing undue delays in training and deployment.[50] This was a serious oversight on the part of the ZAR government by relying on civilians to perform a basic function of government.[51] Several independent field ambulances served the needs of commandos in Natal, the Orange Free State and Transvaal and many were under the management of the State Artillery.[52] The Boer cause drew sympathy in Europe as well as in the United States of America and Russia.[53] As a result of pro-Boer (anti-British) propaganda many volunteered assistance to the Boers.[54]

In particular, medical aid in the form of doctors, nurses and general volunteers, who attempted to establish field ambulances and hospitals in areas of great need, was offered.[55] In the period 1899-1900 the French Ambulance established a fully-equipped 100 bed unit;[56] the Jewish Ambulance established a hospital in Johannesburg and later in Elandsfontein;[57] the Belgian-German Ambulance in Krugersdorp set up a Radiology unit;[58] the Dutch and Netherlands Indies Ambulance set up a 60 bed hospital in Pretoria and enlisted a world-renowned military surgeon, Dr Kuttner, who served in Pretoria and Kroonstad;[59] the Irish-American Ambulance operated in Christiana; the Russian

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49 *Ibid.*
50 *Ibid.*
51 *Ibid.*
52 *Ibid.*
53 *Ibid.*
54 *Ibid.*
55 *Ibid.*
56 *Ibid.*
57 *Ibid.*
58 *Ibid.*
59 *Ibid.*

ambulance was widely active in Colesberg, Pretoria and Modderspruit;[60] the Scandinavian Ambulance operated in Mafikeng, Kimberly and Magersfontein.[61]

These ambulance units were treated with a degree of disdain and by the end of 1900 most returned to their respective countries, leaving behind a small number of medical personnel who had the impossible task of delivering proper care with little equipment at their disposal.[62]

2.6 World War I and World War II

Between 1902 and the end of the South African war and 1914 and the beginning of the First World War there were major developments in military equipment.[63] Automatic weapons were mass-produced; a new artillery vehicle, the tank, was designed and modern ammunition and explosives made short shrift of out-dated offensive and defensive manoeuvres.[64] The lack of proper medical care would result in the deaths of many millions.[65]

The development of new technologically-advanced weapons meant doctors faced unforeseen challenges. The new weapons wreaked havoc.[66] In an effort to curb the growing number of deaths it was a matter of urgency that new treatments and medical technologies were developed.[67] Better organisation and procedures on the battlefield significantly improved the chances of wounded soldiers surviving through

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60 *Ibid.*

61 *Ibid*. Many ZAR commanders initially refused and rejected help from these foreign resources, most notably, President Kruger. According to Denys Reitz, General De La Rey told him that Boer 'bossie-middels' were good enough to treat most ailments.

62 *Ibid.*

63 Robinson J, "Chemical arms control and the assimilation of chemical weapons." (1981) 36(3) *International journal* 515 – 534.

64 *Ibid.* Also see https://www.military.com/army-birthday/history-of-us-army-weapons.html (accessed on 20 March 2017).

65 Van Bergen, L: "Medicine and medical service in: 1914 - 1918" (2014) *International encyclopaedia of the First World War* 1 – 21; *a*vailable at https://encyclopedia.1914-1918-online.net/article/medicine_and_medical_service (accessed on 20 March 2017).

66 https://www.bl.uk/world-war-one/articles/wounding-in-world-war-one#, by Julie Anderson (accessed on 20 March 2017).

67 *Ibid.*

setting up “casualty clearing stations”. Here, limbs were amputated and operations carried out, after which patients were transferred to better equipped and more permanent hospitals set up in abandoned buildings such as churches and residential dwellings.[68]

As the war progressed treatments gradually improved; for example an increase in medical personnel, by providing blood transfusions to soldiers and through the use of x-ray machines which improved surgeons’ ability quickly and effectively to remove fragments of shells and bullets.[69] Despite these advances with an estimated 15 000 – 20 000 people wounded daily and up to 100 000 on exceptional days, millions lost their lives.[70] Although wartime medicine advanced in terms of treatment and technique, civilian healthcare suffered severely, for example in France where a tuberculosis hospital for women and children was evacuated to clear beds for sick and wounded soldiers.[71] The primary concern and interest of the state was to treat and rehabilitate soldiers in order to send them back to the front as soon as possible.[72]

There had been important developments in medicine by the beginning of the Second World War, notably the discovery of penicillin in 1928 and the use of antibiotics.[73] This discovery made the treatment of infections in the sick and wounded much easier than 20 years earlier[74] and millions of lives were saved. Medical personnel were able to administer antibiotics at the front, to a certain extent relieving the constant need to send back troops for weeks on end and wait for reinforcements to arrive.[75]

Although antibiotics aided in the recovery from infections, the advances in weaponry were far ahead of what medical personnel could attempt to treat.[76] Automatic

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68 *Ibid.*

69 *Ibid.*

70 Van Bergen, 1 – 21.

71 *Ibid.*

72 *Ibid.*

73 Fleming, A “The discovery of penicillin” 2(1) (1944) *British medical bulletin* 4 – 5. Available at https://doi.org/10.1093/oxfordjournals.bmb.a071032 (accessed on 20 March 2017).

74 https://www.chemheritage.org/historical-profile/alexander-fleming.

75 Quinn, R “Rethinking antibiotic research and development: World War II and the penicillin collaborative” 103(3) (2013) *American journal of public health* 426 – 434.

76 https://www.bl.uk/world-war-one/articles/wounding-in-world-war-one#, by Julie Anderson (accessed on 20 March 2017).

weapons were more common, the artillery was notably more advanced and aerial warfare had become a pivotal offensive and defensive weapon.[77] Additionally, nuclear weapons, of which little was known at the time, were a terminal threat.[78] The rise in casualties placed medical personnel under severe pressure.[79] An example is the experience of the South African Medical Corps (SAMC) deployed in WW2.[80] The SAMC predominantly was a peacetime unit whose training and equipment were based on First World War experience; [81] they had a severe shortage of ambulances and no hospital train or ship.[82]

The situation changed quickly after Colonel Orenstein took charge of the SAMC in 1939 and saw to the development of resources and the procurement of required ambulances and equipment.[83] Many of the SAMC units, due to a lack of supplies and the rough terrain of North and East Africa, found the situation a challenge.[84] They were unable to adhere strictly to the hygienic standards that were required and as a result for every one battle casualty there were 40 casualties from preventable diseases.[85]

Despite the aforementioned lack of development and preparation that had been experienced, the SAMC made little effort to achieve sustainability between 1945 and 1960.[86] Only in 1960, after a military reassessment, the Surgeon-General implemented the necessary steps to ensure that the SAMC pursued a course of sustainable development and efficiency.[87]

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77 *Ibid.*

78 https://www.un.org/disarmament/wmd/nuclear/. See also http://www.icanw.org/the-facts/the-nuclear-age/ (accessed on 20 March 2017).

79 Greeff, I "The South African Medical Corps during the Second World War" 3(2) (1989) *South African national museum of military history: Museum review* 123 – 138.

80 *Ibid.*

81 *Ibid*.

82 *Ibid.*

83 *Ibid.*

84 *Ibid.*

85 *Ibid*.

86 *Ibid.*

87 *Ibid* 136.

2.7 Military health service after World War II

In the early stages of the Namibian-Angolan border war the SAMC played a vital role providing crucial medical services to the local civilian population and refugees, as well as to soldiers. In 1979 the SAMC was altered to become the South African Medical Service (SAMS) and transformed into an additional limb of the South African Defence Forces.[88] SAMS grew into a division renowned for outstanding service; they set up bush hospitals with functioning theatres in which primary care was administered and the wounded stabilised until they could be transported to permanent facilities in SWA, as well as to 1 Military Hospital in Pretoria if seriously wounded.[89] In June 1998 SAMS was integrated with the former TBVC states' military medical services becoming the South African Military Health Service (SAMHS).[90] SAMHS now primarily is a peacetime division, actively deployed throughout Africa in assisting the South African National Defence Force (SANDF) in peace- keeping missions.

2.8 Conclusion

Military medical personnel have played a key role during armed conflict; their deployment value has increased as technology makes their primary objectives more attainable. International and municipal law perpetually adapt to the role of medical personnel in modern armed conflict and must evolve with these developments. In this light the conduct of medical personnel in the military arena needs be evaluated. The next chapter investigates the ethical and legal obligations of medical professionals during armed conflict, looking at international law and medical ethics to determine the manner in which these systems function to assist medical professionals to carry out their duties.

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88 http://www.mhs.mil.za/aboutus/history.htm (accessed on 20 March 2017).

89 Geldenhuys, JJ *Ons was daar - wenners van die oorlog om Suider-Afrika* (2011) 633 – 645.

90 http://www.mhs.mil.za/aboutus/history.htm (accessed on 20 March 2017).

CHAPTER 3

ETHICAL AND LEGAL OBLIGATIONS OF MEDICAL PROFESSIONALS DURING ARMED CONFLICT: INTERNATIONAL LAW AND MEDICAL ETHICS

3.1 Introduction

In this chapter I discuss the ethical and legal obligations of medical professionals during an armed conflict. I refer to international law principles, the rules of international humanitarian law regarding medical practice in armed conflict and medical ethical codes elaborating guidelines for military medical personnel. First, the fundamental principle of medical ethics and practice needs to be established before the discussion can progress.

The foremost ethical and legal obligation demanded of medical professionals is that they observe the principle of neutrality, which requires medical personnel at all times to remain neutral in fulfilling their duty.[1] This principle it seems bestows a reciprocal responsibility upon those engaged in armed conflict not to interfere with the duties of medical personnel.[2] If there is a responsibility, then an attack on medical personnel violates this principle.[3] An example of this type of behaviour is the manner in which Syrian armed forces attack the Syrian White Helmets, a civilian rescue organisation.[4] This behaviour challenges any attempt by medical personnel in conflict zones to strike a balance between the well-being of their patients, international law and medical ethics. Next I address and discuss the various guidelines, obligations and principles relevant to the role of medical professionals during armed conflict.

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1 Preamble, Statutes of the International Red Cross and Red Crescent Movement (adopted by the 25th International Conference of the Red Cross at Geneva in 1986).

2 Katari, R S "Medical Neutrality and Solidarity in the Syrian Armed Conflict" (2013) 1 *The Journal of Global Health* 33.

3 *Ibid.*

4 *Ibid.* See also http://www.independent.co.uk/news/world/middle-east/white-helmets-seven-paramedics-shot-dead-idlib-province-sarmin-rebel-oscar-netflix-documentary-syria-a7890191.html (accessed on 8 October 2017).

3.2 Regulation of medical care during armed conflict

3.2.1 Geneva Conventions

The Geneva Conventions effectively are the guarantors of protection for the wounded, sick, and shipwrecked in armed conflict. The Geneva Conventions are the product of a process. The first rules and guideline for the treatment of the wounded and sick in armed conflict were introduced in the United States in the form of Instructions for the Government of Armies of the United States in the Field, later officially labelled the Lieber Code of 1863.[5] Although this code was not an international instrument, it was actively followed by the US military until 1914 and is antecedent to the Geneva Conventions.

Realising the need for codified regulations in respect of the wounded and sick in armed conflict, the Geneva Committee drafted an initial proposal in this regard, initiating the process which led to the acceptance of the first Geneva Convention in 1864[6]. The 1864 Geneva Convention established the ICRC and allocated a neutral emblem to medical personnel and it addressed the need to protect wounded and sick combatants and prescribed the treatment of prisoners of war. The effect was to offer the wounded and sick care and protection and to safeguard the neutrality of medical personnel and of civilians.[7]

Soon after it had been drafted it became clear that the 1864 Geneva Convention was insufficiently broad in the protection it provided. Subsequently, the 1864 Geneva Convention was revised in 1906 to offer broader protection to the wounded. Respect for and protection of medical personnel was strengthened in all circumstances by including their sanitary establishments and personnel. Furthermore, captured medical personnel would not be treated as POWs but would continue to exercise their duties.

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5 Paust , J 'Dr Francis Lieber and the Lieber Code' 95 (2001) *American society of international law proceedings* 112 – 114.

6 The Convention for the Amelioration of the Condition of the Wounded in Armies in the Field (1864) 75 UNTS 31.

7 Mehring, S *"First do no harm": Medical ethics in international law* (2014) 83.

Also, it compelled neutral medical personnel to wear the Red Cross emblem at all times.[8]

The drafters of the 1906 Geneva Convention could not anticipate the problems the First World War would present. As a result of the advances in weaponry and modern warfare, an amendment to the Convention was needed to address these challenges. In 1929 the amendment was adopted introducing several important developments. The rights of the sick and wounded were elaborated upon; they were to be protected in all circumstances, dealt with reasonable respect and care and treated in a humane manner. In terms of articles 9 and 12 medical personnel could not be detained if captured and must be repatriated as soon as possible, but also be allowed to exercise their function where they are held.

The treatment of POWs, in companion to the 1929 amended Geneva Convention, was addressed in the Geneva Convention Relative to the Treatment of Prisoners of War[9] ensuring them a basic level of medical care and protection. These efforts were insufficient in protecting POWs and civilians assisting the wounded in the Second World War. The USSR and Japan did not ratify the abovementioned conventions and there were large numbers among POWs and civilian medical personnel who became casualties.[10]

A draft amended convention had been prepared by the ICRC but was overtaken by the outbreak of the Second World War. Afterwards the Geneva Convention was completely overhauled and divided into four separate conventions, namely, the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field,[11] the Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea,[12] the

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8 *Idem* 84.

9 Geneva Convention Relative to the Treatment of Prisoners of War (1929) (see Ch 1 n 31 for citation); “the POW Convention”.

10 Mehring 86 – 87.

11 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in the Armed Forces in the Field (1949) (see Ch 1 n 31 for citation) (“GC1”).

12 Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of the Armed Forces at Sea (1949) (see Ch 1 n 31 for citation) (“GC2”).

Geneva Convention Relative to the Treatment of Prisoners of War,[13] and the Geneva Convention Relative to the Protection of Civilians Persons in Times of War.[14] These conventions were adopted on 12 August 1949 by 64 states.

Significantly, the revised Geneva Conventions altered the wording, referring not specifically to "war" but to "armed conflict", providing protection in non-international armed conflicts. There was still greater protection of the wounded and sick, as well as of medical personnel.

The four Geneva Conventions have been widely accepted and are considered customary international law.[15] As is the case with IHL the application of international law continues to evolve. The liberation of numerous African colonies through armed conflict led state parties to amend the Geneva Conventions to include non-international armed conflict. On 8 June 1977 state parties adopted two Additional Protocols to the Geneva Conventions. The first Protocol Additional to the Geneva Conventions of August 1949 and Relating to the Protection of Victims of International Armed Conflicts[16] deals specifically with international armed conflict, the second, The Protocol Additional to the Geneva Conventions of August 1949 and Relating to the Protection of Victims of Non-International Armed Conflicts[17] relates to non-international armed conflicts. Specific rules apply in the different types of armed conflict in respect of the protection applicable to certain persons. The rules applicable to international armed conflicts with specific reference to medical care are examined next.

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13 Geneva Convention Relative to the Treatment of Prisoners of War (1949) (see Ch 1 n 31 for citation) ("GC3").

14 Geneva Convention Relative to the Protection of Civilians Persons in Times of War (see Ch 1 n 31 for citation) (1949) ("GC4").

15 Mehring 89.

16 The Protocol Additional to the Geneva Conventions of August 1949 and Relating to the Protection of Victims of International Armed Conflicts (1979); (see Ch 1 n 31 for citation) ("AP1").

17 The Protocol Additional to the Geneva Conventions of August 1949 and Relating to the Protection of Victims of Non-International Armed Conflicts (1979); (see Ch 1 n 31 for citation) ("AP2").

3.2.2 Medical care in international armed conflict

The definition of wounded and sick is inclusive of civilian and military persons in need of medical assistance or care as a result of trauma, disease or any other physical or mental disability.[18] Effectively, this definition addresses the shortcoming in GC1 and GC2 by including the wounded and sick among the armed forces and civilians.[19] The medical care provided to these persons is not confined to specific diagnoses in order to avoid narrowing the application of AP1. AP1 places a responsibility on member states to give medical care to the wounded and sick, and not to harm them in any manner; it is applicable to the armed forces and to civilians and the Protocol may not be contravened at any stage for whatever reason, including military necessity. The universal principle of non-discriminatory treatment is reiterated in article 10 of AP1, except for medical reasons. Should the armed forces be forced to abandon wounded and sick combatants their obligation is they equip them with sufficient medical personnel and supplies. In this instance, military necessity can be invoked that the wounded and sick are supplied with limited resources.[20]

Wilful exposure of the wounded and sick to contagious or infectious diseases, as well as torture and non-therapeutic experimentation, is strictly prohibited.[21] This type of protection applies as well to POWs from the moment they are captured until their release. The definition of POWs includes members of recognised armed forces or volunteer corps forming part of the armed forces. Article 44 of AP1 specifically includes militia members who cannot be distinguished by wearing a uniform but openly carry arms. Parties are obliged to search for the wounded and sick after an armed conflict and the detaining party has a duty to provide free medical care and maintenance of POWs.[22] Although there is a duty to provide medical care, the standard of care is not described or regulated and POWs are left to the generosity of their captors. The drafters mention that the medical care must be “as efficient” as possible, but the vagueness of

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18 A 8 of AP1. Note that those who commit an act of hostility are excluded from this definition.

19 Mehring 91.

20 *Idem* 92 – 93.

21 A 49 and 50 of GC1. Also referred to as “Grave Breaches” and were included as a result of the atrocities committed *inter alia* by the German armed forces during World War 2.

22 A 15 of GC3.

the duty leaves room for interpretation by medical personnel to transgress IHL rules.[23] A stricter approach in defining the nature of care would be appropriate.

Civilian victims of armed conflict, for instance as a result of the occupation of territory, are to be treated first by civilian medical personnel in civilian medical facilities. Civilians are to be protected, respected and treated humanely in terms of article 27 of GC4. Inherently, this provision applies to the captured wounded and sick as well. The sanctity of civilian hospitals or medical facilities at all times must be respected, unless they are used as a base to commit acts of hostility.[24] In the event civilians have been detained by the occupying party for imperative security reason they are entitled to medical care as required for their general well-being, which care shall not be of a lesser standard than that provided to the general population.[25] Detained persons, including civilians, are protected against being victims of unwarranted medical treatments or procedures, barring emergency treatment.[26] The various articles ensure the theoretical protection of civilians to a certain extent. A level of protection also is afforded doctors, which aspect is examined next.

The protection under IHL extends to medical personnel however they forfeit that protection by an act that infringes their ‘neutrality’ such as by contributing to hostilities. The Geneva Conventions do not declare who are regarded as medical personnel; they are identified only by exercising their function.[27]

Those not specifically protected under any of the categories in the Geneva Conventions or Additional Protocols are safeguarded as civilians under articles 18 of GC1, 17 of AP1 and 18 of AP2. AP1 defines medical personnel as those assigned exclusively to the search, collection, transportation, diagnosis or treatment of the wounded, sick and shipwrecked or for the prevention of disease.[28] In order for them to be protected they need to be recognised as such by one of the parties to the conflict.

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23 Mehring 97 – 98.
24 A 18 and 19 of GC4.
25 A 56, 91 and 92 of GC4.
26 A 11 of AP1.
27 Mehring 107.
28 A 8 of AP1.

Protection applies to civilian doctors as well but only to those who are *officially* assigned to engage in medical activities by one of the parties. Absolute protection applies to permanent medical personnel alone, temporary personnel have conditional protection.[29] There are three categories of protected military personnel; first, military medical personnel in terms of article 24 of GC1 who are protected only when carrying out their duties as defined in articles 24 and 25 of GC1 and comply with the identification requirements as set out in article 42 of GC1. Second, medical personnel of duly-recognised and authorised national Red Cross and voluntary societies are protected when they carry out their duties as stipulated in article 24 of GC1 and are subject to the military laws of their country. Lastly, members of a neutral state's recognised societies will enjoy protection as contemplated in article 27 of GC1 only if the neutral state has given consent to their participation in the conflict and one of the parties to the conflict has authorised their participation. Such authorisation must be communicated to the opposing party as soon as possible to ensure the safety of the medical personnel. These persons have to be identifiable as is required of the former two categories.[30]

To summarise, medical personnel enjoy absolute protection under the Geneva Conventions if their employment meets certain administrative conditions, they are identifiable and they carry out certain medical duties applicable to the wounded and sick.[31] Medical personnel cannot be captured by the enemy, they can be detained. They can be used to carry out their medical functions to the benefit of the POWs of the country to which they belong if their service is required.[32] They may not be detained indefinitely and must be repatriated as soon as is possible practically.[33] On being detained and required to provide medical services to POWs, they do so in accordance with the military laws and regulations of the detaining power. They have to be provided with the means to carry out their duties as instructed and to the benefit of the POWs of their country.[34] Medical personnel from humanitarian aid organisations or neutral states

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29 Mehring 108.
30 Mehring 109.
31 *Idem* 110.
32 A 28 of GC1 and A 33 of GC3.
33 A 30 of GC1.
34 Mehring 111.

may not be detained and should be allowed to return to their country or party of affiliation.[35] In essence, military medical personnel and personnel of neutral aid societies may be detained; all other medical personnel must be repatriated.[36]

Medical personnel must be identifiable at all times. The parties to an armed conflict must ensure that their medical personnel display the correct identification as stipulated in articles 40 of GC1, 42 of GC2 and 20 of GC4.[37] Recognised and authorised medical personnel wear a white armlet, issued and stamped by their military authority, showing the Red Cross, Red Crescent or Red Crystal emblem. They are required to carry an identification card issued by their state of origin.[38] The author suggests updating these methods of identification in response to technological advances.

3.2.3 Medical care in non-international armed conflict

Various internal armed conflicts required the introduction of the Additional Protocols, specifically AP2 which deals with non-international armed conflicts. The regulation of medical care in non-international armed conflict is examined next. The basis of the treatment of victims of non-international armed conflict, including those *hors de combat*, is Common Article 3[39], which determines that they must be treated in a humane manner. AP2 addresses the shortcomings in Common Article 3 and establishes the principles applicable to internal armed conflicts. AP2 applies in situations where an armed conflict takes place in a state's territory between the armed forces and organised armed groups in sufficient control of part of the territory to enable such groups to carry out sustained and concerted military operations and to implement AP2.[40] Terrorist activity does not fall in its ambit of protection.[41]

The humane treatment of the wounded and sick is addressed in Common Article 3, but is not defined as an established level of care and appears to be dependent upon

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35 A 32 of GC1.

36 Mehring 113.

37 Also addressed in A 18 of AP1.

38 A 16 of GC1 and 19 of GC2 require the carry of identity cards. A 40 of GC1 and 42 of GC2 set out the requirements thereof.

39 Common Article 3 of the Geneva Conventions 1 - 4.

40 A 1(1) of AP2.

41 A 1(2) of AP2.

circumstances. It prohibits acts which commonly are unacceptable or offend the public conscience such as torture and non-therapeutic experimentation.[42] Discrimination in treatment is strictly prohibited except for medical reasons.

However Common Article 3 fails to address discrimination based upon nationality whereas the GC1-4 lists that form specifically. The GCs state that the wounded and sick must be protected and respected, whereas Common Article 3 requires only that they be searched for and cared for. This requirement was phrased deliberately in that way to ensure that states are not obliged to protect terrorists.[43] AP2 extends the protection provided to the wounded and sick, including those who are *hors de combat,* to terrorists by directing that they not only must be searched for and cared for but also be protected and respected. They also must receive the required medical care as clinically indicated with the least possible delay and without discrimination.[44] AP2 protects detained persons as well by stipulating that they should not be subjected to unjustified acts or omissions which endanger their physical or mental health and integrity.[45]

The abovementioned conduct is prohibited but in non-international armed conflict there appears not to be penalties for 'grave breaches' as there is in international armed conflict. However some states integrate penalties for breaches into domestic legislation.[46] AP2 extends the protection offered in Common Article 3 in that it establishes protection for medical personnel as well as for the performance of their duties.[47] They should be provided with the necessary supplies and assistance to exercise their duties and may not be compelled to conduct acts which contravene their humanitarian mission, such as torture, non-therapeutic experimentation or even purely military objectives.[48]

Article 10 provides an umbrella protection for all medical personnel, including psychologists and midwives. It stipulates that no medical personnel may be punished

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42 Mehring 121.
43 *Idem* 122.
44 A 7 of AP2.
45 A 5 of AP2.
46 Mehring 124. Some of these States include the United Kingdom, Germany, and Canada.
47 A 9 and 10 of GC2.
48 *Ibid*.

for medical activities as long as these are in line with medical ethics. Forced revelations of medical confidentiality are prohibited but the prohibition needs strengthening. The article merely states that professional obligations should be respected and are regulated by domestic legislation.[49] If domestic legislation is poorly drafted, then the protection is limited. Although doctors have been empowered and protected to a certain extent against forced breaches of medical ethics and into treatment detrimental to their patients, it is difficult to enforce these provisions as there is no system of penalties for "grave breaches".[50]

Despite the abovementioned protective measures, they are insufficient in practice as a result of their ambiguity. Consequently medical personnel work in conflict at great personal danger. They work under conditions that are less than ideal and under immense pressure and a heavy workload and with limited resources. These rules need clarification in an amendment and must be more specific to ensure that medical personnel are not left without support.

3.3 Medical professionals in armed conflict

Various types of medical professional are present in an armed conflict and certain guidelines are presented in terms of the distinct nature of their profession. Most prevalent are physicians. They are an inherent part of the military framework, their own wounded are a priority, but they must act in accordance with international humanitarian law which dictates that they must attend to *all* wounded combatants irrespective of their allegiance.[51]

Also, there are civilian physicians who work in the civilian hospitals/clinic and other institutions of a state party to an armed conflict. In general, they see to the well-being of the civilian population but in line with ethical obligations they may not discriminate against wounded combatants of any party if they present for treatment in

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49 Mehring 126.

50 *Idem* 127.

51 Mehring, S *First do no harm: medical ethics in international law* (2013) 9.

their institution.[52] It is important to be cognisant that private practitioners, who are not employed in civilian hospitals by one of the state parties to the conflict, are not protected under the laws of armed conflict. Lastly, there are the personnel of humanitarian organisations (mostly NGOs) operating within conflict zones, such as Doctors Without Borders ("MSF"), the White Helmets, the International Committee of the Red Cross and national Red Cross organisations. To be protected by IHL article 9(2) of Additional Protocol 1 (AP1) states that they will have received the consent of a party to the conflict and must undertake to be impartial.[53] IHL applies to all parties in an armed conflict and consequently to humanitarian organisations as well. Under these terms they must treat *all* persons requiring medical attention as stipulated in Common Article 3: "persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed *hors de combat* by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, *without any adverse distinction* founded on race, color, religion or faith, sex, birth or wealth, or any other similar criteria".[54]

The above-mentioned are the first on the scene and the first to evaluate the condition of the wounded; in effect they are the first identifiers of human rights violations.[55] However, this circumstance makes them susceptible to violent attack from groups aggrieved by the fact that they are impartial and attend to all combatants.[56] Their actions are construed as treachery with the result that medical stations are attacked.[57]

In light of the numerous guidelines and obligations that rest on medical personnel in armed conflict, in principle it is simply that they are guided by humanitarian law principles. There are four main humanitarian law principles to which doctors must

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52 *Ibid.*

53 *Idem* 10. Additional Protocol to the Geneva Conventions of 1949 relating to the Protection of Victims of International Armed Conflicts (1977) (see Ch 1 n 31 for citation).

54 *Ibid.* Common Article 3 of Additional Protocol to the Geneva Conventions of 1949 relating to the Protection of Victims of International Armed Conflicts (1977) (see Ch 1 n 31 for citation).

55 Mehring 11 – 12.

56 Katari, R S "Medical neutrality and solidarity in the Syrian armed conflict" (2013) 1 *The journal of global health* 33.

57 *Ibid.*

adhere in armed conflict, namely, humanity, neutrality, independence, and impartiality, each is investigated below.[58]

3.3.1 Humanity

The principle of humanity is the basis of IHL and is fundamental in the modern medical profession in accordance with article 1(2) of AP1, which states: "in cases not covered by the Protocol or by other international agreements, civilians and combatants remain under the protection and authority of the principles of international law derived from established custom, from the principles of humanity and from the dictates of public conscience".[59] 'Humanity' is a check and balance restricting the actions of military personnel in their quest for victory by all means;[60] it limits military necessity in as far as their actions may not violate this principle.[61] 'Humanity' attempts to prevent suffering and harm as much as is possible, though a level of harm is inherent to the procedure in order to provide satisfactory treatment.[62] It attempts to protect the well-being of the patient and to save lives.[63] It requires that the wounded be treated with respect at all times, including those of an opposing allegiance.[64] This principle is applicable to all medical personnel, civilian and military.[65]

3.3.2 Impartiality

'Impartiality' ensures that doctors are able to practice their trade, irrespective of their allegiance, although practice shows it is not always the case, hence articles 6, 7, 10, 12, and 19 of GC1 and articles 10(2) and 16 of AP1.[66] The private practitioner is untouched, but the principle is crucial in armed conflict if there is to be no discrimination against the

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58 Mehring 13.

59 *Idem* 14. A 1(2) of Additional Protocol to the Geneva Conventions of 1949 relating to the Protection of Victims of International Armed Conflicts (1977) (see Ch 1 n 31 for citation).

60 *Ibid.*

61 *Ibid*.

62 *Idem* 14 – 15.

63 *Idem* 15.

64 *Ibid.* Pictet, J *Development and principles of international humanitarian law* (1985) 63.

65 *Ibid*.

66 *Ibid.* Geneva Convention I: Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Additional Protocol to the Geneva Conventions of 1949 relating to the Protection of Victims of International Armed Conflicts (1977) (see Ch 1 n 31 for citation).

wounded based on non-medical criteria, as is presented in the example of *Nicaragua v United States of America*.[67]

This demand should not be over-emphasised as the ability by humanitarian organisations to provide medical care to any party to an armed conflict is greatly dependent upon the consent of that party.[68] This principle is made up of three additional aspects, namely non-discrimination, proportionality, and subjective impartiality.[69] 'Non-discrimination' is self-explanatory and is not permitted on grounds other than medical criteria.[70] 'Proportionality' requires that medical care is provided as is clinically indicated and needed.[71] 'Subjective impartiality' requires that medical personnel not only appear to be impartial, but also conduct themselves in such a manner that demonstrates impartiality. [72] This aspect requires that doctors act in an impartial manner, but not that they are neutral.[73]

3.3.3 Neutrality

This principle requires neither participating nor interfering in a conflict, be it by means of military actions or ideologically.[74] The ICRC defines neutrality as not taking sides in hostilities or in controversies of a political, racial, religious or ideological nature.[75] For military medical personnel this principle will be controversial, as they inherently are members of the armed forces of one of the state parties to the conflict.[76] But we must take into account that their protection is dependent upon their neutrality during the conflict.[77] Obviously, this will not be as difficult for doctors associated with humanitarian

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67 *Case concerning military and paramilitary activities in and against Nicaragua (Nicaragua v United States of America)* (1986) International Court of Justice Reports 14.

68 Mehring 16.

69 *Ibid.* Also see Common Article 3.

70 *Idem* 16.

71 *Ibid.*

72 *Ibid.* Also see Haug, H *Humanity for all* (1993) 460.

73 Mehring 16.

74 *Idem* 17.

75 Preamble to the Statutes of the International Committee of the Red Cross. (Hereafter "the ICRC").

76 Mehring 17.

77 *Ibid.*

organisations or private practitioners as they are not active service personnel.[78] However, neutrality will remain challenging for all doctors in armed conflicts.

3.3.4 Independence

This principle requires that in their work doctors are free from third party influence, which includes but is not limited to governments and other political, religious, or financial interests. As the focus of their activities should be the well-being of humanity, medical personnel have a right to refuse to give effect to certain orders from superiors if these are in contravention of IHL or municipal law. It is intended that these circumstances ensure that patients do not suspect bias or develop the fear of substandard care and the presence of associated ideological issues.[79] The notion of 'independence' has a different practical implication in respect of the three types of doctors when they are imbricated in the situation of armed conflict, mentioned *supra*.

Civilian doctors as well face a challenge in maintain a posture of independence and neutrality as most likely they practice in a medical facility of a state party to the conflict. There is a suspicion that they may be biased in providing treatment to enemy combatants, but they must not allow this impression to influence their response to the exercise of their sole focus of delivering the best possible care. [80]

This principle is crucial to the work of humanitarian organisations such as the ICRC as they are not affiliated with any party to the conflict. The ICRC specifically is defined as a neutral and independent organisation.[81] For the ICRC the consent of the parties in charge of the area within which they wish to operate and in carrying out their mandate requires they are neutral and independent. By way of contrast MSF does not request consent with the result it faces greater danger in carrying out its work. Nevertheless, as is the case with the ICRC, MSF insists its members respect their professional code of conduct and are free of political, economic or religious influence.[82]

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78 *Idem* 17.

79 *Idem* 18 – 19.

80 *Idem* 19.

81 A 6 of the ICRC Statute.

82 MSF Charter available at www.msf.org.

Humanitarian organisations adhere to the principles of neutrality and independence and avoid the suspicion of bias by refraining from seeking military protection. [83]

Military medical personnel are faced with a dilemma in terms of satisfying their dual function: Are they doctors first and soldiers second? They are active service personnel and the needs and requirements of their compatriots come first. They are never regarded as being independent or neutral but are viewed as "tainted" by having a certain political and ideological point of view. Their primary concern is the well-being of the active service personnel of the state and not an enemy combatant. They have a right to refuse to execute orders that are in contravention of IHL and/or municipal laws.[84] At some point they may confront a choice either to assist a compatriot or an enemy combatant, which introduces their dilemma and raises a question whether making a choice means that military medical service necessarily is an unethical or at least a dysfunctional practice.

The abovementioned four guidelines cannot be viewed in isolation. In that they are dependent on one another they must be interpreted holistically. It seems military medical personnel require an individual code of ethics and that the vacuum in terms of a proper and all-encompassing ethical guide must be addressed. This need is applicable especially in the areas of concern involving military medical personnel discussed below.

3.4 Involvement of military medical personnel in questionable conduct during armed conflict

3.4.1 Introduction

In general the guidelines discussed above should assist medical personnel in armed conflict to perform their duties guided by medical ethics and IHL. They are able to refuse to obey direct orders which violate medical ethics as article 16(2) stipulates: "Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit

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83 Mehring 22.

84 *Idem* 22 – 25.

of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions".[85] The discussion of torture and interrogation practices relates to the potential for violations of the article and illustrates the contradictions medical personnel deal with.[86]

3.4.2 Medical personnel involved in torture and interrogation practices.

The involvement of doctors and allied health care practitioners in torture and interrogation is controversial.[87] In particular, practices at the Guantanamo Bay detention facility have been thoroughly scrutinised revealing the high level of involvement by doctors.[88] The targets for interrogation are prisoners of war or persons of interest who may be involved in hostile activities.

The Geneva Conventions protect detainees against this type of treatment.[89] Specifically, this protection is referenced in Conventions III[90] and IV.[91] Common Article 3 and the Convention against Torture and other Cruel, Inhuman, or Degrading Treatment of Punishment are of special note.[92] This type of interrogation is alleged to expedite the process of obtaining information and during interrogation some person with medical expertise is sought to assess the condition of detainees before, during and/or after the interrogation despite their involvement being prohibited by medical ethics.[93]

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85 A 16 of the Additional Protocol to the Geneva Conventions of 1949 relating to the Protection of Victims of International Armed Conflicts (1977) (see Ch 1 n 31 for citation). Hereafter "AP1".

86 Mehring 18 – 19.

87 Wolfendale, J "Professional integrity and disobedience in the Military" (2009) 8:2 *Journal of military ethics* 127 – 140.

88 Meriwether, LM "After Abu Ghraib: Does the McCain Amendment, as part of the 2006 Defense Appropriations Act, clarify US interrogation policy or does it tie the hands of US interrogators?" (2006) 14:1 *Tulsa journal of comparative and international law* 156.

89 Includes a variety of persons in detention. The term does not attempt to assign a specific legal status to them.

90 Geneva Convention relative to the Treatment of Prisoners of War (1949) (see Ch 1 n 31 for citation). Hereafter "GC3".

91 Geneva Convention relative to the Protection of Civilians in Time of War (1949) (see Ch 1 n 31 for citation). Hereafter "GC4".

92 Convention against Torture and other Cruel, Inhuman, or Degrading Treatment of Punishment 26 July 1987, 1465 UNTS 85. Hereafter "the Torture Convention".

93 Miles, SH "Abu Ghraib: Its legacy for military medicine" (2004) 364 *Lancet* 725 – 729.

The requirement is that the doctor keeps alive the detainee and regulates his pain levels or increases his ability to stay in a cooperative state.[94]

In the initial phase of the 'war against terror' in 2002 the United States of America[95] approved new 'counter resistance techniques' to be used in the interrogation of detainees at Guantanamo Bay.[96] These techniques included stress positions, isolation for extended periods of time, deprivation of light, twenty-four hour interrogations, forced nudity, forced grooming, deliberate exposure to phobias, mild non-injurious physical contact and deprivation of non-emergency medical care.[97] In January 2003 blanket approval of these techniques was withdrawn but they could be specially requested for use on certain detainees and were regularly applied under medical supervision by the Central Intelligence Agency[98].[99] In April 2003 the following measures were introduced as a safeguard, including that the detainee was medically evaluated as suitable for a combination of interrogation techniques, an interrogation plan was specifically developed with adequate intervals in application and if medical personnel were available, appropriate supervision, and senior supervisory approval thereof with any detainee.[100]

The limitations placed on these techniques regularly were updated by the CIA's Office of the Medical Services (OMS), *inter alia*, exposure to extreme temperatures and noise levels to ensure that the subject would not permanently be debilitated.[101] The US Army Field Manual permitted certain pre-approved interrogation techniques but the above mentioned techniques far exceeded the limits listed in the Field Manual. After the extensive involvement of medical personnel came to light the Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States was introduced in 2005.

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94 Mehring 49.
95 Hereafter "the US" or "the USA".
96 Meriwether 160.
97 Mehring 50.
98 Hereafter "the CIA".
99 Mehring 51.
100 *Idem* 52.
101 *Ibid.*

This measure established certain principles to which medical personnel were required to adhere and strictly prohibited their involvement in interrogations in violation of 'applicable laws'.[102] The wording of the programme (i.e., 'applicable laws') was strategic so as to exonerate any person involved in such activities under the jurisdiction of states who were not parties to the conventions against torture and humanitarian laws. Furthermore, the programme was not applicable to medical personnel involved in 'non-treatment activities' such as psychologists and psychiatrists working on behavioural assessments, as well as to forensic pathologists.[103]

The violations of the Geneva Conventions at the detention centre in Guantanamo were brought to an end by the judgment in *Hamdan v Rumsfield*[104] which reaffirmed that Common Article 3 applies to all those (detainees) deprived of their liberty. Subsequently, the American Medical Association (AMA), the American Psychiatric Association, and the World Medical Association (WMA) amended their guidelines to prohibit the involvement of medical personnel in interrogation techniques.[105]

The media, the general public and critics were unimpressed by the guidelines contained in the 2005 programme, which led to the implementation of the Medical Program Support Detainee Operations in 2006. An amendment worthy of note is the clear distinction made between medical personnel in a 'patient-provider relationship' and others who were involved in 'non-treatment activities'. The latter were excluded from any 'patient-provider relationship' with detainees. Those involved predominantly were from a psychological/psychiatric background undertaking behavioural assessments. Those in 'patient-provider relationships' were left in charge of medical screening and the monitoring of detainees in so far as these were required during interrogation sessions. The 2006 programme provided that medical personnel must not

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102 *Idem* 54.

103 *Ibid.*

104 Salim Ahmed Hamdan v Donald H. Rumsfield, Secretary of Defence, and others, United States Supreme Court (2006).

105 Mehring 55.

be placed in a position in which they advise on interrogation techniques or the duration of application.[106]

Based on their observations behavioural assessors presented custom-designed interrogation approaches for specific detainees and would advise interrogators to adjust their approach to the detainees' unforeseen behaviour. The forensic pathologists allegedly engaged in fraudulent activities in that they falsified the death certificates of interrogated detainees by omitting crucial evidence of severe and inappropriate interrogation techniques used upon the deceased In order that liability would not fall on the interrogators or on US government officials.[107]

These examples are evidence that military medical personnel do not always exercise their duties in a neutral manner. The persons involved in the interrogations confronted a dilemma in having to choose between their responsibilities as members of the armed forces with a specific mandate and the demand that a medical professional "*do no harm".* The challenge was that in disobeying an order to participate in these types of interrogations might damage their career. Irrespective of whether they faced a difficult choice, opponents of medically assisted or supervised interrogations, including the ICRC, ruled the participation in these interrogations a gross breach of medical ethics.[108]

There is an argument that the presence of medical personnel will mitigate the harm to the detainee and improves the detainee's chances of survival. Doctors not necessarily act with maleficent intent, but are acting in accord with the detainee's medical instructions. Their presence it is argued in some degree could 'humanise' the interrogation process. These arguments are nullified by the possibility their presence gives the impression that the detainee will cope with the interrogation and that the doctor will ensure the detainee's survival. The inability or unwillingness of a doctor to intervene or instruct the interrogator may be interpreted as permission to proceed.[109] Such behaviour inevitably leads to a loss of faith in the medical personnel and the care

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106 *Ibid.*

107 *Idem* 59 – 60.

108 Mehring 61.

109 *Idem* 63.

delivered as a source of comfort and alleviation from suffering, which does not conduce to respect for medical ethics or the profession.

The involvement of psychiatrists in a behavioural assessment capacity has resulted in a breach of medical confidentiality. Their role is not to care for the mental state of the detainees but to tailor interrogation approaches to the specific requirements in breaking the detainee, resulting in a gross breach of medical ethics. There is no substance to the explanation that they are not in 'provider-patient relationships' and therefore acted as soldiers and not medical professionals, implying that they follow a different set of ethical guidelines.[110] Even in respect of psychologists, although they do not have a medical degree, this behaviour is considered unethical. Any attempt to justify the breach of confidentiality based upon a defence other than the prevention of disease is to be disregarded. In this case the purpose of such a breach is to inflict harm upon the detainee and is a violation of IHL[111] and their conduct is unethical.

3.4.3 Medically induced force-feeding of detainees on a hunger-strike

Hunger strikes are a passive demonstration of dissatisfaction with certain aspects of detention against those who are in charge of the detention facility. It can be a powerful weapon to bring about change in a non-violent manner as usually the hunger strikers do not intend to die. The WMA defines a hunger strike as "a form of protest by people who lack other ways of making their demands known. In refusing nutrition for a significant period, prisoners and detainees may hope to obtain certain goals by inflicting negative publicity on the authorities", usually lasting longer than 72 hours.[112]

However, the justification for medical intervention is controversial. Most doctors will intervene when they are of the view that the intervention is necessitated by circumstances, alternatively, if it is in the best interest of the patient. During 2005 allegedly 133 detainees were on a hunger strike at Guantanamo. In terms of the 2006 programme force feeding was permitted without consent if it is to prevent death or

110 *Idem* 64.

111 *Idem* 65.

112 World Medical Association Declaration of Malta Hunger Strikers (1991) paragraph 1.

serious harm.[113] In general force feeding is unacceptable except for preventing death. Military physicians often tend to hunger striking detainees and are conflicted as they bear responsibility for the health of the detainees. As do doctors whose goal is humanitarian, they feel they have no choice in deciding whether to feed the detainees. Both report only on the healthcare situation; it seems as if the former doctors have greater success in treating hunger strikers as they are not perceived as complicit with the detaining power.[114]

The final decision in medical intervention ultimately vests in the attending doctor. The first moment for a decision is when the health of the detainee deteriorates to such an extent that intervention is necessitated. Next, it needs to be decided if force feeding is required. Doctors differentiate between force feeding, which is self-explanatory, and artificial feeding when the detainee no longer is conscious or is medically competent to make decisions of life and death or, alternatively, when the hunger striker consents.[115]

Medical personnel strike a fine balance between the instructions of their superiors in ordering force feeding and the wishes of the hunger striker. They must appear to be neutral and to act in the best interest of the patient. The doctor must decide whether the well-being of the detainee or his integrity at the risk of death is more important. In any event many hunger strikers consider force feeding a form of torture. If a detainee makes an informed decision to continue with his hunger strike and gives consent not to receive medical treatment, most doctors accept an autonomous decision.

According to the WMA Declaration of Tokyo[116] if a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he shall not be fed artificially. The decision regarding the capacity of the prisoner to make such a decision should be confirmed by at least one other independent doctor. The consequences of his refusal should be properly explained by the doctor to the prisoner.

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113 Mehring 67.

114 *Idem* 71.

115 *Ibid.*

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

In these circumstances the person is regarded as a 'competent hunger striker' and should not be fed even if his health deteriorates.[117] It is clear that when a hunger striker does not consent to nourishment and is force fed such conduct is considered unethical.

However, at this stage IHL does not provide a satisfactory answer as to how doctors should treat a prisoner of war on hunger strike and is dependent on the detaining forces.[118] The interrogation process at all times must adhere to medical ethics and IHL. A violation of IHL and/or medical ethics could lead to prosecution either in the International Criminal Court or in a domestic court. In order to gain a better understanding of the ethical and practical obligations of medical personnel the legal framework in which they operate needs be examined.

3.5. Codes of medical ethics

3.5.1 World Medical Association

The World Medical Association (WMA) is a voluntary organisation of national medical associations and was established on 18 September 1947.[119] Their objective is to achieve the highest international standards in medical education, science, art, ethics, and health care for all people of the world.[120] They pursue this goal by adopting various declarations which issue a directive to members to which they must adhere. However, these documents are not considered law and are merely guidelines to which the medical fraternity looks for guidance in ethical practice.[121] They are binding only upon those members whose national medical associations are members of the WMA.[122] A few important declarations adopted by the WMA are examined next.

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117 Mehring 74.

118 *Ibid.*

119 www.wma.net (accessed on 8 October 2017).

120 Art 2 of the Articles and bylaws of the World Medical Association (1978).

121 Mehring 361.

122 *Idem* 376.

The first declaration adopted by the WMA in 1948, the Declaration of Geneva,[123] is a consequence of the atrocities committed by doctors under National Socialism. The objective was an attempt to draft a modern day Hippocratic Oath, which would impress upon newly-qualified doctors the fundamental ethics of medicine and would assist in raising the general standards of professional conduct.[124] Shortly thereafter, in an effort to supplement the Geneva Declaration, the WMA adopted the International Code of Medical Ethics[125] which emphasises the important role of medical care in armed conflict. In terms of the Declaration the most important undertakings are those regulating the patient-provider relationship.

The Code is divided into three parts; the general duties of doctors, the duties of doctors to their patients and lastly the collegial relationship between doctors.[126] There are differences in these documents but in certain areas they overlap and supplement each other. The overlap establishes further protection for patients and doctors to that offered in the Declaration where it is made clear that the patient is the doctor's primary concern and doctors may not use their knowledge to violate human rights. The Code dictates that the doctor must respect the patient's dignity and act to their benefit, reveal to patients when they are acting on behalf of third parties and as far as possible obtain informed consent.[127]

Since their adoption numerous declarations have been issued in line with the evolution of IHL and as a result of certain events. The Washington Declaration on Biological Weapons[128] prohibits the use of biological weapons and urges researchers to consider the risks and responsibilities involved in their work. Of particular relevance to the discussion is the Declaration of Hamburg,[129] which explicitly supports medical personnel experiencing difficulties by their refusal or objection to participate in torture or

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123 World Medical Association, Declaration of Geneva (1948).

124 www.wma.net (accessed on 8 October 2017). See also Mehring 389.

125 World Medical Association, International Code of Medical Ethics (1949).

126 *Ibid*. Also see Mehring 389 – 390.

127 Mehring 399. Declaration of Geneva (1948). International Code of Medical Ethics (1949).

128 World Medical Association Declaration of Washington on Biological Weapons (2002).

129 World Medical Association Declaration of Hamburg concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman, or Degrading Treatment (1997).

inhumane treatment. The WMA has adopted a Resolution on the Responsibility of Physicians to document acts of torture,[130] which obliges national medical associations to ensure that victims of torture have immediate access to health care and that proper records of the examination are safeguarded. The Istanbul Protocol[131] is to be widely distributed among medical personnel and asserts that training is provided with regard to the obligations in the Resolution.

This Resolution specifically focuses on the responsibility and ability of physicians to recognise injuries inflicted under torture and to conduct a thorough examination and assist with the subsequent investigation.[132] This focus is to be read in conjunction with the Declaration of Tokyo[133] which provides that physicians shall not consent to or provide any assistance whatsoever to the practice of torture, save to provide alleviation to the prisoner when it is necessary or requested. The WMA calls upon the national bodies to recognise the role physicians play in whistle blowing in terms of this type of conduct and to provide adequate support to those in distress as a result of their objection to participation.

The WMA, the International Committee of Military Medicine (ICMM), the International Council of Nurses (ICN) and the International Pharmaceutical Federation (FIP) were consulted by the ICRC in order to establish a blanket document containing ethical principles of medical care during armed conflict and related emergencies. The various organisations adopted a general endorsement of ethical principles confirming that ethics during armed conflict do not differ from peace time ethics, that medical professionals may not participate in the practice of torture and that they must be

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130 World Medical Association Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003).

131 Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment *United Nations Publication* (2004). This protocol substantively deals with the procedural aspects of torture investigations, and more specifically the collection of evidence.

132 World Medical Association Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment (2003).

133 World Medical Association Declaration of Tokyo – Guideline for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention or Imprisonment (2005).

protected for executing their duties in accordance with the law and ethical obligations.[134] These principles initially had been canvassed in the Istanbul Protocol[135] and were successfully summarised in the Ethical Principles.[136] It does not detract from the merits of the Istanbul Protocol[137] and simultaneously makes the Principles[138] simpler and more accessible. These declarations are not binding legal documents but are guidelines for medical personnel to follow. Most medical associations are in agreement that the WMA does not have the necessary authority to make rules for doctors.[139]

The declarations add value to IHL but tend to be superfluous when they no longer regulate the patient-provider relationship. The ethical principles embedded in these declarations should not be regarded as the *locus classicus* of medical ethics in IHL but are supplementary as guidelines when IHL does not provide sufficient clarity in a situation or in the consideration of an ethical problem.[140] Below is a brief examination of the prosecution of medical professionals who engaged in gross violations of ethical principles.

3.6 The Nuremberg Doctors' trial: *United States of America v Karl Brant et al*

The Nuremberg Doctors' trial was held in the Nuremberg Palace of Justice from 21 November 1946 until 20 August 1947.[141] These doctors had conducted various experiments divided into two categories on prisoners held in concentration camps;[142] there were experiments which related to battle conditions such as high altitude and

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134 World Medical Association Ethical Principles of Health Care in times of Armed Conflict and Other Emergencies (2014).

135 Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment *United Nations Publication* (2004).

136 World Medical Association Ethical Principles of Health Care in times of Armed Conflict and Other Emergencies (2014).

137 Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment *United Nations Publication* (2004).

138 World Medical Association Ethical Principles of Health Care in times of Armed Conflict and Other Emergencies (2014).

139 Mehring 419.

140 *Ibid.*

141 Moll, F & Krischel, M & Fangerau, H *Skeletons in the closet: indignities and injustices in medicine* (1) (2012) 79 - 83. See also *USA v Karl Brandt et al (Case 1).*

142 Moll, F 80.

secondly there were experiments pertaining to genetic research and convictions relating to the superiority of races.[143] A prominent experimenter in relation to racial and genetic subjects is Dr Josef Mengele, a SS officer and a physician who volunteered for duty in the concentration camps and was ordered to Auschwitz.[144] Mengele performed live surgery without anaesthesia and had a particular interest in twins.[145] The full extent of his research is unknown as most of his observations which were sent to his PhD supervisor, Omar von Verschuer, were destroyed.[146] Mengele managed to escape capture by the Allies and fled to South America where he died in 1979; he was not tried at Nuremberg.[147]

Another infamous physician is Dr Aribert Heim, also an SS officer, who was stationed at the Mauthausen-Gusen concentration camp.[148] Heim conducted experiments on prisoners by injecting toxic substances directly into their hearts, performed surgery without anaesthesia, and removed organs from healthy prisoners and abandoned them in theatre leaving them for dead.[149] Heim had a special interest in the preparation of human heads of which several were displayed at KZ Gusen Pathological Museum or sent to his friends as special gifts or used as paper weights on his desk.[150] Heim served a two-year prisoner of war sentence, after which he continued to practice medicine in Germany until 1962 when his actions were discovered and he fled to Egypt to avoid prosecution.[151] Heim died in Egypt in 1992, but his death was confirmed only in 2009.[152]

Another doctor at Mauthausen-Gusen, Hermann Richter, surgically removed vital organs from prisoners to determine how long a person can survive without that organ.[153] The executive camp doctor at Mauthausen-Gusen during the period of 1941 – 1943,

143 *Ibid.*
144 *Ibid.*
145 *Idem* 81.
146 *Ibid.*
147 *Ibid.*
148 *Ibid.*
149 *Ibid.*
150 *Ibid.*
151 *Ibid.*
152 *Ibid.*
153 *Ibid.*

Eduard Krebsbach, killed prisoners by injecting phenol directly into their heart.[154] Krebsbach was sentenced to death by the Military Tribunal and executed on 27 May 1947.[155]

Dr Karl Brandt and 22 others, of whom 20 were medical professionals, were known National Socialists and assisted in the execution of the atrocities committed against the Jewish population and were charged with the following offences:[156]

a) Count 1: The Common Design or Conspiracy
   i. Between September 1939 and April 1945 all of the accused herein, acting pursuant to a common design, committed war crimes and crimes against humanity, as defined in Control Council Law No. 10, Article II.
   ii. It was a part of the common purpose to perform medical experiments upon concentration camp inmates and other living human subjects, without their consent, in the course of which experiments the accused committed the murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts, more fully described in counts two and three of this indictment.
b) Count 2: War Crimes

i. Between September 1939 and April 1945 all of the accused herein unlawfully, wilfully, and knowingly committed war crimes, as defined by Article II of Control Council Law No. 10, in that they were involved in medical experiments without the subjects' consent, committing murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts. Such experiments included, but were not limited to, high altitude, freezing, malaria, sterilisation, poison, mustard gas and transplantation experiments.[157]
ii. Between June 1943 and September 1944 the accused Rudolf Brandt and Sievers unlawfully, wilfully, and knowingly committed war crimes, as defined by article II of Control Council Law No. 10, in that they were involved in enterprises

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154 *Ibid.*

155 https://collections.ushmm.org/search/catalog/pa1171484 (accessed on 3 March 2019).

156 A full list of charges can be obtained at https://www.jewishvirtuallibrary.org/indictments-in-the-doctors-trial (accessed on 3 March 2017). See also *USA v Karl Brandt et al (Case 1)* 6.

157 A full list and description of the various experiments can be obtained at https://www.jewishvirtuallibrary.org/indictments-in-the-doctors-trial (accessed on 3 March 2017).

involving the murder of civilians and members of the armed forces for research purposes.[158]

iii. Between May 1942 and January 1944 (Indictment originally read "January 1943" but was amended by a motion filed with the Secretary General. See Arraignment, page 18) the accused Blome and Rudolf Brandt unlawfully, wilfully, and knowingly committed war crimes in that they were involved in the murder and mistreatment of tens of thousands of Polish nationals. These people were alleged to be infected with incurable tuberculosis.

iv. Between September 1939 and April 1945 the accused Karl Brandt, Blome, Brack, and Hoven unlawfully, wilfully, and knowingly committed war crimes, as defined by Article II of Control Council Law No. 10, in that they were involved in the execution of the so-called "euthanasia" program of the German Reich in the course of which hundreds of thousands of human beings were murdered.

c) Count 3: Crimes Against Humanity

i. Between September 1939 and April 1945 all of the accused herein unlawfully, wilfully, and knowingly committed crimes against humanity, as defined by Article II of Control Council Law No. 10, in that they were involved in medical experiments, without the subjects' consent, committing murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts.

ii. Between June 1943 and September 1944 the accused Rudolf Brandt and Sievers unlawfully, wilfully, and knowingly committed crimes against humanity, as defined by Article II of Control Council Law No. 10, in that they were involved in the murder of German civilians and nationals of other countries.

iii. Between May 1942 and January 1944 [Indictment originally read "January 1943" but was amended by a motion filed with the Secretary General. See Arraignment, p. 18] the accused Blome and Rudolf Brandt unlawfully, wilfully, and knowingly committed crimes against humanity, as defined by Article II of Control Council

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158 One hundred and twelve Jews were selected for the purpose of completing a skeleton collection for the Reich University of Strasbourg. Their photographs and anthropological measurements were taken. Then they were killed. Thereafter, comparison tests, anatomical research, studies regarding race, pathological features of the body, form and size of the brain, and other tests, were made. The bodies were sent to Strasbourg and defleshed.

Law No. 10, in that they were involved in the murder and mistreatment of tens of thousands of Polish nationals.

iv. Between September 1939 and April 1945 the accused Karl Brandt, Blome, Brack, and Hoven unlawfully, wilfully, and knowingly committed crimes against humanity, as defined by Article II of Control Council Law No. 10, in that they were involved in the execution of the so called "euthanasia" program of the German Reich.

d) Count 4: Membership in Criminal Organization

i. The accused, Karl Brandt, Genzken, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Brack, Hoven, and Fischer are guilty of membership in an organization declared to be criminal by the International Military Tribunal in Case No. 1, in that each of the said defendants was a member of the **SCHUTZSTAFFELN DER NATIONALSOZIALISTISCHEN DEUTSCHEN ARBEITERPARTEI** (commonly known as the "SS") after 1 September 1939. Such membership is in violation of paragraph I (d), Article II of Control Council Law No. 10.

After a trial lasting 140 days, which heard the testimony of 85 witnesses and saw the submission of an estimated 1,500 documents, the verdict was delivered on 20 August 1947.[159] Of the 23 accused, 16 of the doctors were found guilty and seven of those, including Karl Brandt, were sentenced to death and hanged at Landsberg War Criminal Prison on 2 June 1948.[160] The remaining nine doctors were sentenced to incarceration for a minimum of 10 years to life although none of them served more than eight years of their sentences.[161] The remaining seven accused were discharged.[162] After delivering their verdict the presiding judges voiced their concerns regarding medical experimentation and handed down guidelines to be followed in medical experimentation which effectively today is known as the Nuremberg Code of Medical Ethics.[163]

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159 Moll 81. See also *USA v Karl Brandt et al* 256.

160 *Ibid.*

161 *Ibid.*

162 *Idem* 82.

163 *Ibid.*

3.7 Conclusion

The Karl Brandt trial was critical to the development and adoption of many of the above-mentioned declarations, conventions and guidelines. Some of these are relatively recent, but the foundational principles of IHL have a longer history. Military doctors who transgress the principles expressed in the declarations and guidelines that have been discussed violate IHL rules. To restate the core issue at stake means to resolve the dilemma of whether medical personnel foremost are soldiers or doctors, and, should they be prosecuted for violations of their responsibilities, are they to be permitted to practice in the civilian health services considering their previous conduct. Brandt *et al* clearly acted in the manner they had while practicing as doctors. In the next chapter I examine the case of Dr Wouter Basson the erstwhile head of South Africa's biological weapons research programme known as Project Coast.

CHAPTER 4

DR WOUTER BASSON: A CASE STUDY

4.1 Introduction

In this chapter I examine Dr Basson's career in the military, his criminal trial and the disciplinary hearing before the HPCSA. I start by outlining Basson's involvement in the military and, subsequently, in Project Coast. Next I discuss the criminal trial which is a direct result of his involvement in Project Coast. Finally, I comment on the disciplinary hearing, which is a follow-up to Basson's involvement in Project Coast and his criminal trial.

4.2 Background

Dr Wouter Basson was the head of South Africa's chemical and biological weapons programme, named Project Coast, during the period from 1981 to 1992.[1] At that time he was directly involved in the manufacturing of chemical and/or biological weapons for the South African Defence Force (SADF) and, to a limited extent, the South African Police and Civil Co-operation Bureau.[2]

Dr Basson obtained a degree in medicine in 1973[3] and joined the South African Medical Services (SAMS) in 1979 as a Lieutenant Medical Officer. His intellect was swiftly recognised by his superiors.[4] Basson continued his studies and qualified as an internal medicine specialist and was registered with the HPCSA in 1980. He was promoted to substantive Commander in March 1981.[5] It is reported that from the outset Basson had a special interest in chemistry; he obtained a master's degree in

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1 Gould, C and Folb, P *Project Coast: Apartheid's chemical and biological warfare programme* (2002) United Nations institute for disarmament research (UNIDIR), United Nations 19. See also *S v Basson* TPD CC 32/99 [1].

2 *Idem* 18.

3 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo) (accessed 2 September 2018).

4 Gould *et al* 41

5 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo) (accessed 2 September 2018). See also Gould *et al* 43.

Physiological Chemistry in 1978.[6] From March 1981 onwards he served as special advisor at Defence Headquarters and as Project Officer of the Special Projects of the Surgeon-General.[7]

Basson rapidly rose in the ranks in the SADF and at the end of his career held the rank of Brigadier.[8] In 1985 he had been promoted to the rank of Colonel and Head of 7 Medical Battalion which provided medical support to the Special Forces, Parachute Division, the SAPS and National Intelligence.[9] In 1988 with the rank of Brigadier he headed Medical Staff Operations and then became head of Research and Development in SAMS.[10]

His military service formally came to an end in 1993,[11] but by a decision in cabinet in 1995 he was reinstated by the SANDF.[12] The US and UK intelligence services had expressed concern about Basson's links with Libya and demanded some form of government assurance that he would be held accountable. He was expected to protect the South African government's chemical and biological warfare information and to tie up the remaining 'loose ends' of Project Coast as the project was being dismantled at that stage.[13] After finalising his work for the military in 1996 Basson again studied further; this time cardiology. He registered as a cardiologist with the HPCSA in 1997.[14]

Project Coast was the SADF's chemical and biological warfare programme. Basson was the driving force behind Project Coast and was afforded considerable leeway by his superiors as he reported only to the Head of Special Operations and to the Minister of Defence who, in turn, reported to the President of the Republic.[15] The

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6 *Ibid.*

7 Gould *et al* 43.

8 *Idem* 19.

9 *Idem* 43.

10 *Idem.*

11 *Idem* 209. See also *S v Basson* para 8.

12 The South African Defence Force was renamed the South African National Defence Force shortly after the 1994 democratic elections.

13 Gould *et al* 210. See also *S v Basson* para 8.

14 *Idem* 210.

15 *Idem* 16.

normal chain of command was circumvented for Project Coast and the prescribed procedures for covert operations also were disregarded.[16] It was only after former President De Klerk ordered General Pierre Steyn to begin an investigation into so-called "Third Forces" that Project Coast came under scrutiny and eventually was decommissioned.[17]

4.3 Project Coast

South Africa's involvement in the production of chemical weapons started during World War II through the production of quantities of mustard gas for the Allied Forces in factories situated near Chloorkop on the outskirts of Johannesburg and at Firgrove in the Cape.[18] Production ceased in July 1945 after sufficient quantities had been produced and the war had come to an end.[19] There is little evidence to suggest that South Africa was involved in the production of chemical weapons during the period 1945 to 1960.

The Chemical Defence Unit of the Council for Industrial and Scientific Research (CSIR) established a company called Medchem which was tasked with the investigation and monitoring of chemical warfare agents on behalf of the SADF.[20] The CSIR proved to be an ideal recruiting ground for the SADF's special needs and in the early 1970s Dr Jan Coetzee was head-hunted by General Malan to head the Defence Research Institute for the purposes of developing counter-intelligence equipment for the then Special Operations Group.[21] There is no evidence that chemical agents were produced on a large scale during the period 1961 to 1980.[22]

The motivation in initiating Project Coast was a purported threat of chemical and biological warfare at the hands of the Soviet Union and its allies, as well as being an

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16 *Ibid*. See also *S v Basson* para 4.
17 *Ibid.* See also *S v Basson* para 7.
18 *Idem* 31.
19 *Ibid.*
20 *Idem* 32.
21 *Idem 35.*
22 *Idem* 34.

attempt to wean South Africa from dependence on the North Atlantic Treaty Organisation (NATO) for the supply of and research into chemical and biological weapons.[23] Also there is a conjecture that in the late 1970s SADF troops confiscated vehicles from Cuban forces which allegedly contained chemical agents such as nerve gas antidotes and gas masks.[24] This speculation is refuted by a report that upon closer inspection of the vehicles it was established that they were embalming vehicles. This information apparently was not conveyed to the high command in the SADF.[25]

In 1990 a report was released which claimed that the People's Movement for the Liberation of Angola (MPLA) forces were using chemical weapons against the National Union for the Total Independence of Angola (UNITA) forces, later this claim was refuted during Basson's criminal trial[26] by soldiers who had served in the area.[27] Another report by Delta G Scientific (a front company of the SADF) confirmed that traces of chemical weapons had been found in shrapnel of MPLA ammunition used against UNITA.[28] Basson confirmed the presence of chemical weapons at the front and presented the explanation that the munitions used by MPLA forces contained specific chemical compositions which upon combustion released saltpetre and cyanide in the smoke, as well as high concentrations of tricresolphosphates which convert into poisonous phosphine gas and leave traces of poisonous metal phosphides in the soil and water.[29] These munitions caused paralysis of UNITA soldiers and allegedly were reported on by the SADF forces who treated their condition.[30]

The SADF gave the public the impression that there was an imminent threat of chemical or biological warfare against them, but the soldiers were ill-equipped to deal

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23 *Idem* 36 – 37.
24 *Idem* 38.
25 *Ibid.*
26 *S v Basson* 2000 (4) SA 479 (T) (unreported judgment).
27 Gould *et al* 39.
28 *Ibid.*
29 *Ibid.*
30 *Idem* 40.

with such a situation as it appears that 7 Medical Battalion had only between 10 and 20 Nuclear, Biological and Chemical Suits (NBC Suits) available at any given time.[31]

These speculations have to be measured against the backdrop of a 1988 memorandum from General Savides sent to senior SADF officers – including Basson – that a briefing on chemical and biological weapons was to be held to discuss the acquisition of chemical and biological weapons equipment to ensure the battle-readiness of certain operational divisions as well as training procedures for these divisions.[32] The inference being that some type of chemical or biological weapons threat had been identified. It is unknown if the threat was real or perceived, in 1982-3 the SADF spent R 418 200 000.00 on Project Coast. R 37 000 000.00 allegedly was misappropriated by Basson and his colleagues,[33] However this allegation was not proven at Basson's criminal trial.[34]

In order to preserve the secrecy of Project Coast several front companies were established in 1982 to conduct research under the auspices of the SADF.[35] Delta G Scientific and Roodeplaat Research Laboratories (RRL) were established and respectively were responsible for the research and/or development of chemical and/or biological weapons on a small scale.[36] Delta G Scientific produced CR teargas whereas RRL focused mainly on research and development into chemical and biological weapons which were untraceable *post mortem.*[37] Some of the products that were manufactured by the front companies of Project Coast include ecstasy, MDMA (a derivative of ecstasy), BZ (an incapacitating agent), CS (teargas), CR (an improved form of CS which causes severe irritation among recipients), cholera and several other poisons and heavy metal poisons.[38]

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31 *Idem* 41.

32 *Idem* 109 – 110. General Savides was the Director of Army Projects at that point in time.

33 *Idem* 113.

34 *Idem* 113. *S v Basson* 2000 (4) SA 479 (T).

35 *Idem* 3.

36 *Idem* 8.

37 *Ibid.*

38 *Idem* xiii, 3 – 5, 7 – 9, 87 – 88.

Subsequent to President De Klerk entering office Project Coast was renamed Jota for security reasons[39] and Basson was tasked with decommissioning and finalising the work of Project Coast.[40] Jota was transferred to the responsibility of a new commanding officer, Colonel BP Steyn, to oversee the finalisation of the projects. It was decommissioned in 1995.[41] Basson's involvement in Project Coast and his extensive international dealings eventually would be an integral part of his criminal trial and HPCSA hearings.[42]

4.4 Basson's criminal trial in the Gauteng Division of the High Court

Basson was arrested on 29 January 1997 by the Narcotics Division on suspicion of dealing in ecstasy and was released on bail.[43] The evidence found in trunks in his and in an associate's possession formed the basis of the drug charges against Basson.[44] He was arrested again in October 1997 for fraud-related offences, and when his bail hearing finally commenced several state departments, including the Attorney-General, launched formal applications for the hearing to proceed *in camera* in order to protect state secrets and to prevent their proliferation.[45] Initially, the judge ruled in their favour, but the Freedom of Expression Institute together with the media challenged this decision. After a two-year-long court battle the hearing finally was ruled open to the public.[46]

The 67 charges brought against Basson included 229 murders, attempted murder, 24 charges of fraud to the amount of R 36 000 000.00, assault with the intent to

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39 *Idem* 41.

40 *Idem* 209.

41 *Idem* 41.

42 *S v Basson* 2000 (4) SA 479 (TPD).

43 *Idem* 231 and *S v Basson* para 10. According to Gould and Burger (in their book *Secrets and Lies: Wouter Basson and the South African chemical and biological warfare programme)*, Detective Ehlers executed the arrest in Magnolia Dell, Pretoria. Shortly thereafter, Ehlers' cell phone was inundated with calls from SADF generals and from lawyers wanting to know what is going on. This information was obtained from an online preview of the book with page numbering unavailable as the book no longer is in print.

44 *Ibid.*

45 *Ibid.*

46 *Ibid.*

do grievous bodily harm, possession of 3 158 ecstasy capsules and 38.6 grams of powdered ecstasy, dealing in methaqualone, possession of cocaine, alternatively possession of 100 000 mandrax tablets and 1 200 kilograms of methaqualone, procurement of 500 grams of Thymus peptide, Thymosin and 500 kilograms of methaqualone which allegedly he intended to purchase in Croatia in 1992.[47] These were serious charges and related to Project Coast. They could have resulted in a long prison sentence for Basson.

The trial commenced in the Pretoria High Court in October 1999 with prominent lawyers representing both parties. The state was represented, among others, by Dr Anton Ackermann SC, Dr Torie Pretorius and two additional junior prosecutors, Basson was represented by Adv. Jaap Cilliers SC and Adv. MMW van Zyl.[48] The trial began with the defence raising an exception to charges relating mostly to crimes allegedly committed outside the Republic or Basson allegedly conspiring to commit such crimes outside the Republic by arguing that section 18 of the Riotous Assemblies Act 17 of 1956 and the common law fail to make conspiracy a crime and that the accused cannot be prosecuted for crimes allegedly conspired to and/or later committed outside the Republic.[49]

The court found that Basson qualified under a general amnesty[50] applicable to all South African security force members who operated in Namibia before 1989 and that he cannot be prosecuted for crimes committed outside the Republic despite their being planned here and being committed by South African citizens.[51] Consequently, six of the charges against Basson were dropped.[52] In respect of the amnesty the prosecution argued that the acts committed were not in the general scope of military duties, but the

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47 *Ibid.* See also Swart, M "The Wouter Basson prosecution: the closest South Africa came to Nuremburg?" 68 (2008) *Journal of foreign public law and international law* 209 – 226 available at http://www.zaoerv.de/68_2008/68_2008_1_b_209_226.pdf (accessed 12 September 2018).

48 *S v Basson* 2000 (4) SA 479 (T). Adv Ackermann SC and colleagues were replaced by Adv W Trengove SC when the matter was heard in the Constitutional Court. Adv MMW Van Zyl has since been conferred with senior status.

49 *S v Basson* 2000 JDR 0059 (T). *S v Basson* 2000 (1) SACR 1 (T) paras 6, 9 – 11.

50 Administrator-General Government Notice 16 of 1990.

51 Gould *et al* 232.

52 *S v Basson* 2000 JDR 0059 (T) *S v Basson* 2000 (1) SACR 1 (T) 17.

court rejected that argument.[53] In regards to the drug-related charges, Basson denied throughout that he had sold drugs to anyone and all that the state managed to prove was that the ecstasy found in Basson's vehicle was from the same batch that had been prepared by Delta G Scientific researcher Dr Koekemoer.[54]

The state-appointed forensic auditor, Hennie Bruwer, was asked to compile a report to prove that Basson had misappropriated SADF funds for personal, familial, and collegial gain and that he and his colleagues in fact were the beneficial owners of several front companies used in this endeavour.[55] Basson denied these allegations stating that he had simply used these companies to maintain his cover and to protect the SADF with regard to questionable procurements.[56] The court concurred with Basson that the companies had acted to the benefit and in the interest of the SADF and not for Basson's personal benefit.[57]

Basson was exhaustively questioned about his extensive international travels and his lavish lifestyle, which was confirmed by state witnesses, but to no avail. Basson maintained that his travelling was necessary as he was required to conduct the business of Project Coast under the cover of being an international businessman.[58] Basson confirmed that he chose his international business associates carefully and purposefully for their experience in circumventing sanctions against the South African government and that many of the properties he purchased in fact were on behalf of and on the instructions of his international associates.[59]

The court then turned to the human rights violations and murder charges against Basson, some of which had been committed outside the Republic but which were conspired to within the country. Members of the CCB and SADF testified as to their instructions to "eliminate" enemies of the state, some of whom were SADF members,

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53 Gould *et al* 232.

54 *Idem* 233.

55 *Ibid.* See also *S v Basson* para 16.

56 *Ibid.*

57 *Ibid.*

58 *Idem* 235.

59 *Idem* 236 – 237. *S v Basson* 2000 JDR 0059 (T). *S v Basson* 2000 (1) SACR 1 (T). See also *S v Basson* para 15.

and how they murdered these targets and disposed of the bodies.[60] In this regard the court found that although the events appeared to have transpired the witnesses' version that Basson supplied them with several substances to administer to the targets was false and that they implicated and testified against Basson only for the purpose of saving themselves by obtaining section 204 indemnity.[61] The state attempted to call some of Basson's international associates to testify against him but the court denied the application, citing the credibility of the testimony of these witnesses as the main concern.[62]

In June 2001 the court acquitted Basson of 15 charges relating to the murders, fraud, assault, conspiracy to commit murder and dealing in drugs.[63] In order to secure a conviction on the human rights violations such as the attempted murders of ANC members and extrajudicial killings through chemical weapons allegedly provided to operators by Basson the state had to prove that Basson was involved directly in the manufacturing and exchange of weapons for assassination.[64] Despite testimony by scientists which confirmed the manufacture of the weapons and operators confirming the use, Basson denied that he was involved in the manufacturing and supply to operators of such weapons. Consequently, no causal link could be established and he was acquitted on these charges as well.[65] The state also failed in their prosecution of Basson for the possession of top secret chemical and biological weapons documents found in the trunks in Basson's vehicle and residence. Basson claimed he did not know to whom they belonged nor who had packed the trunks and in these circumstances conviction was impossible.[66]

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60 *Idem* 236. See also Swart 211 and *S v Basson* para 12.

61 *Ibid. S v Basson* 2000 JDR 0059 (T); *S v Basson* 2000 (1) SACR 1 (T). See also *S v Basson* paras 1985 – 1998.

62 *Idem* 239. *S v Basson* 2000 JDR 0059 (T)*. S v Basson* 2000 (1) SACR 1 (T).

63 *Idem* 239 – 240.

64 *Idem* 240.

65 *Ibid.* See also *S v Basson* para 2018.

66 *Idem* 238. Mr Goosen, in his testimony during Basson's trial, said that of the 203 project files found in Basson's possession after his arrest in 1997, 177 dealt with biological weapons. The other 26 related to "soft" or commercial projects. Of the 177, 34 dealt with antidotes and treatment for biological agents and of these, only three were final reports.

On 11 April 2002 after a marathon trial of over 300 court days and involving more than 150 witnesses the court acquitted Basson on all charges.[67] The most significant findings the court made are the following:[68]

a) Basson was not the person who supplied drugs to Wentzel, the police decoy. The decoy was in search of ecstasy long before he spoke to Basson and was able to secure the drugs without Basson. The police also knew beforehand that the decoy was dealing in drugs and although he tried his best to implicate Basson in the telephone conversations about which he testified, he could not succeed in doing so. The court upheld Basson's version of events as being more probable.[69]

b) The state failed to prove that Basson packed or instructed a third party to pack, the trunks containing top secret information about Project Coast found at the time of his arrest and that he had stored them at the house of an associate. The evidence proved that Basson and another collected the trunks from Mijburgh who was supposed to capture the information on CDs and then destroy the hard copies. Basson believed that the data-capturing was completed and the hard copies destroyed in accordance with his orders. The court held that Basson's version that he was unaware that the hard copies were not destroyed but were in storage reasonably could be true.[70]

c) The state failed to prove that the alleged drug tablets produced at Speskop during 1985 contained methaqaulone. The only testimony in this regard was that of Beukes who indicated that he did not know what was the composition of the tablets.[71]

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67 *Idem* 240.
68 *S v Basson* para 2131.
69 *Idem* 1.
70 *Idem* [2].
71 *Idem* [3].

d) In light of the above Basson was acquitted on charges 25 – 27 and the already discharged charges 28 – 30.[72]

e) Theron, Phaal, Floyd and Bothma, together with van der Linde, were involved in missions where persons who were identified as a security threat to the state were eliminated and their bodies disposed of in the ocean (usually by helicopter). The court accepted their self-incriminating evidence.[73]

f) It was improbable that Theron, General Loots and Basson discussed the supply of scoline and tuberine to Theron to inject into targets. The explanation for this finding is that according to Theron's evidence the discussion took place during or before September 1980 but at that stage Basson was not in charge of these operations at Speskop, he was only a clinical assistant and as such could not have supplied the substances to Theron. The evidence of Theron and Bothma was mutually destructive after which the court concluded that Theron's evidence was unreliable and should be disregarded.[74]

g) Basson's denial that he ordered Bothma to accompany Theron to Dukuduku to experiment with a potentially-lethal salve on hostages was accepted. Bothma's explanation for making the trip was improbable as Theron testified that Basson was not involved in this mission to eliminate the targets.[75]

h) In light of the above the court concluded that Bothma alone linked Basson to the alleged plot to murder the hostages and Basson was acquitted on charges 32 – 35, 42 – 44, 47 – 50, 53 and 56. Basson was already discharged on charges 39 – 41.[76]

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72 *Idem* [4].
73 *Idem* [5].
74 *Idem* [6].
75 *Idem* [7].
76 *Idem* [8].

i) No evidence was presented linking Basson to any chemical interrogations of hostages at Orlando Christina.[77]

j) The report allegedly drafted by Basson in this regard was not found to be a police report according to police evidence nor a military report according to military evidence. In accordance with the testimony of Van Niekerk the report in any event could not have incited anyone to commit the purported acts as the decision to do so was taken long before the report was drafted.[78]

k) Accordingly Basson was acquitted on charges 36 – 37.[79]

l) It is highly unlikely that someone would have given Phaal a substance to administer to a target which causes the target to bleed profusely out of the territory of the Republic with the instruction to repatriate the target in that state. It would be nonsensical to conduct an experiment in that manner. The entire operation would need to have been executed either in the Republic or outside it. The evidence of Phaal and Theron contradicted each other as neither convincingly indicated what had happened to the target. Theron persisted in his denial that he ordered Phaal to travel to Namibia to execute the mission.[80] Consequently Basson was acquitted on charge 45.[81]

m) Theron testified about an alleged burning of a body. His testimony was severely criticised, especially in implicating Basson. There was no indication of when or how the deceased died. Basson was subsequently acquitted on charge 51.[82]

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77 *Idem* [9].
78 *Idem* [10].
79 *Idem* [11].
80 *Idem* [12].
81 *Ibid.*
82 *Idem* [14].

n) The murder of De Fonseca was peculiar. The state indicated that he did not die as a result of thalium poisoning. However, they persisted in attempting to implicate Basson in the murder. The state evidence was so unconvincing that Basson had been discharged on charge 52 early on in the trial.[83]

o) Although Basson was not formally charged with the conspiracy to assassinate Messieurs Jordan and Kasrils in London by means of a make-shift weapon to administer a poison, nevertheless the state led the evidence of Floyd, Mr Q and Dr Lourens. Lourens testified that the poison was not supplied by Basson but by Mijburgh, Floyd testified that Lourens said that Basson supplied the poison. Lourens conceded that he had adapted his evidence to fit in with that of Floyd. The workshop where these devices had been manufactured was under the direct supervision of Lourens. Basson denied any role in the supply of a device or poison.[84]

p) With regard to the conspiracy to assassinate the Honourable Chikane the state failed to prove that Basson was aware of the fact that Dr Immelman supplied paraoxon to Chris, Gert and Manie (CCB operators) and that as a result Chikane became ill. The state failed in an attempt to prove by the testimony of Burger that Chris, Gert and Manie had administered a substance applied to Chikane's clothing as Burger testified to the exact opposite. Basson already was discharged on charge 57.[85]

q) Basson was not charged with the murder of Knox Dhlamini but evidence was led to show that the thalium allegedly used to poison Dhlamini originated from Roodeplaat Research Laboratories. The state could not prove the poisoning.[86]

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83 *Idem* [15].
84 *Idem* [17].
85 *Idem* [17].
86 *Idem* [18].

r) The state could not prove that Basson was aware that the baboon foetus which was hung from a tree in Archbishop Tutu's garden was the same one that originated from Roodeplaat Research Laboratories.[87]

s) The state could not prove that the foetus was placed there to intimidate Tutu as van der Walt testified that the purpose had been to discourage his followers.[88] Basson therefore was acquitted on charge 59.[89]

t) Basson was not aware of the plot to assassinate Mr Omar by means of digoxin powder. If he had been aware of the plot, he immediately would have advised that the plot was impracticable as digoxin is not an effective substance for this purpose. Basson was acquitted on charge 60.[90]

u) There is no evidence that Basson was aware of the cholera bacterium that Dr Immelman supplied to CCB operators. Neither is there evidence that anyone knew of the failed attempt at cholera contamination.[91]

v) With regard to the attempted distribution of poisoned beer throughout the Eastern Cape Theron is the sole witness to the alleged plot with Basson. Theron's evidence differed from that of Engelbrecht as they could not identify accurately the brand of the beer. Neither could Theron explain who the targets were and how the beer would reach the targets. Basson's denial of knowledge of this plot was accepted and he was acquitted on charge 62.[92]

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87 *Idem* [20].
88 *Idem* [21].
89 *Idem* [22].
90 *Idem* [23].
91 *Idem* [24].
92 *Idem* [25].

w) The state was unable to prove that Basson was aware that RRL was being abused by the CCB. The CCB was a highly clandestine unit and the "need-to-know"-principle was adhered to strictly. The fact that Basson was requested to assist in the disbandment of the CCB in the early nineties does not make him aware of their dealings. Basson therefore was acquitted on charge 64.[93]

x) The state's contention was rejected that the WPW-companies were an alter ego of Basson. There is ample evidence that the WPW-companies in fact were front companies utilised in Project Coast, most prominently the commercialisation and privatisation funds.[94]

y) The averment that Basson was the undisputed owner of WPW was rejected as Webster accepted that Basson held the shares in his name on behalf of his principals who did not want their identities made public. This arrangement was not put in place to benefit Basson to the detriment of the principals.[95]

z) Basson's business associates abroad at all times were aware that they were participating in sanction-busting to the benefit of the SADF.[96] The SADF in turn was aware of those who were dealing with their interests and looked after them.[97]

aa) The state testified to the privatisation of Delta G and RRL after they had been exposed as front companies of the SADF. It appears that everything was above board as the respective purchase prices were calculated by the purchasers and the take-over was presented to the Auditor-General as well as to the State Attorney for their approval, which evidently was granted. The internal auditor of Delta G and RRL was not approached for his insight into the purchase prices and

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93 *Idem* [26] – [27].
94 *Idem* [28].
95 *Idem* [29].
96 *Idem* [30].
97 *Idem* [31].

stated that if he had been approached he would have reported that in his opinion there were discrepancies in the amounts booked.[98]

bb) The state, realising their evidentiary conundrum, requested the court to evaluate the evidence in the manner a jury member would. This request was refused as the state must prove its case beyond reasonable doubt, a failure to do so would mean acquittal. The state submitted a version of the facts that Basson had embezzled the funds mentioned in charges 1 – 19 and 65 – 67 without any return to the SADF. Consequently, if the court were to evaluate the evidence as would a jury member, then the state decides what is the truth and the court must ignore any evidence to the contrary. A further implication to this approach is that once the state *prima facie proves there is a case* the accused has a burden of proof to discharge. In effect, the state required Basson to account for his management of Project Coast as well as for every cent spent. That approach rightly was rejected by the court.[99]

cc) The court further found that Basson's submission that they bought proximity fuses with funds that were transferred from one defence budget to another could be true. Despite the state's scepticism, there is no evidence to suggest any wrongdoing.[100]

dd) There were suspicious circumstances surrounding some of the hazmat suits that were purchased from van Remoortere as the state alleged these suits were the property of the SADF. The evidence in this regard was confused and fragmented with conflicting versions regarding the number of suits produced as well as the

98 *Idem* [55].
99 *Idem* [57].
100 *Idem* [58].

need for additional procurement of suits as the SAMS already had sufficient stock.[101]

ee) The principals of Project Coast were satisfied that there was sufficient financial control over the budget, but after concerns were raised in respect of the international transactions the budget was transferred to the Head of Staff Finance.[102] Subsequent to the transfer of the budget to HSF an investigation was initiated into the flow of the project funds and irregularities at Delta G and RRL were identified.[103] The auditor of Project Coast was satisfied that all payments were in order and legitimate and declared he was aware of the WPW companies' transactions.[104]

ff) The state contended that Basson embezzled most of the R37 million budget of the projects. However, the court was baffled as to how Basson stole R 37 million out of a total budget of R37 million without anyone noticing. The state-appointed forensic auditor, Mr Bruwer, conceded that the alleged stolen funds could have originated only from the original R37 million and that there were no procurement irregularities.[105] The court inferred that Basson might have utilised some of the privatisation funds with permission to pay for the Jetstar aeroplane knowing that the funds from the sale of the synthesiser would become available.[106] It is a plausible conclusion that Bruwer incorrectly assumed certain facts in tracing the funds and payments for BZ and methaqualone and perhaps confused the two transactions creating the illusion that there were fraudulent transactions.[107]

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101 *Idem* [59].
102 *Idem* [60].
103 *Idem* [31].
104 *Idem* [62].
105 *Idem* [63] – [64].
106 *Idem* [65].
107 *Idem* [66].

gg) The state could not prove that the procurements referred to in charges 1–13 and 15-18 did not materialise. As a result no irregularity could be proven regarding charges 65–67and charge 21 also failed.[108]

Consequently, Basson was acquitted and left the court a free man.

4.5 Subsequent appeals: The Supreme Court of Appeal & Constitutional Court

Almost immediately afterwards the state brought an application for leave to appeal to the Supreme Court of Appeal (SCA) and partially succeeded in this application.[109] The state appealed the refusal of the recusal application as well as the refusal to admit the bail record into evidence and to hear arguments on its admissibility.[110]

The SCA found the state's application to be riddled with error, and that the court *a quo* made the correct finding in refusing the recusal application and that the refusal to allow the bail record into evidence would have resulted in an unfair trial.[111] Furthermore, the state could appeal only findings based on errors in law not against errors of fact. In the event that the question reserved becomes academic the appeal must fail. On these grounds the appeal was dismissed.[112]

Dissatisfied with the judgment of the SCA, the state sought relief in the Constitutional Court (CC). After filing the relevant portions of the record of proceedings in the High Court and SCA, which amounted to almost 22 000 pages, the CC granted leave to appeal.

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108 *Idem* [67] – [68].
109 *Ibid. S v Basson* 2002 JOL 9680 (T) 19 – 21.
110 *S v Basson* (2003) 3 All SA 51 (SCA).
111 *Ibid.*
112 *Ibid* 118 – 119.

In essence, the appeal in the CC dealt with three issues, namely whether the conduct of the judge during the trial proceedings was such as to give rise to a reasonable perception of bias. Secondly, whether the trial court was wrong to exclude the evidence led in bail proceedings from the criminal trial and, thirdly, whether the state is entitled effectively to appeal against the quashing of certain charges at the outset of proceedings at that late stage and if so, whether those charges were wrongly quashed.[113]

In summary, the CC found that the trial court had erred in law by finding that in terms of section 18(2)(a) of the Riotous Assemblies Act 17 of 1956, the court did not have the power to adjudicate on a conspiracy within South Africa to commit an offence beyond its borders and subsequently set aside the High Court judgment which acquitted Basson on six charges of conspiracy to commit murder.[114] In every other respect the appeal was dismissed.[115]

Now it was possible for the state to proceed with the prosecution against Basson on these six charges. Several months after the CC judgment was delivered the state decided not to prosecute Basson on these charges for fear of an *autrefois acquit* defence because of the overlap between the conspiracy charges and the other charges on which he already he had been tried and acquitted.[116]

These proceedings raise a question as to why the state had not introduced the rules of international law into the prosecution and indictment.[117] Customary international law is absent in the indictment. If it had been included, Basson would have had a more difficult task convincing the courts of his innocence.[118] It is common cause that the

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113 S v Basson 2005 (12) BCLR 1192 (CC) 1.

114 *Idem* 265.

115 *Ibid*.

116 Swart 212.

117 S 232 of the Constitution, 1996.

118 Swart 218.

armed conflict in Namibia between the SADF and liberation movements is construed as a non-international armed conflict and, therefore, Common Article 3 is applicable. It would mean that Basson had been in transgression of the Geneva Conventions.[119]

There are those who argue that since the offences were committed to further the interests of 'apartheid' government policy Basson ought to be prosecuted in terms of the Apartheid Convention,[120] which is part of customary international law.[121] However, the value of this argument is moot as the Rome Statute merely reaffirms that 'apartheid' is a crime under customary international law and this definition cannot be applied retrospectively to prosecute Basson in the International Criminal Court.[122] Therefore, such a prosecution would be stillborn. The fact that Basson could be prosecuted locally under customary international law ought to have been utilised by the prosecution in order to strengthen their case

The CC stated that Basson was a member of the SADF and was subject to the Defence Act 42 of 2002, which in fact establishes a substantial causal link between the crimes committed in Namibia and in South Africa.[123] Furthermore, at that stage Namibia was under the administration of the South African government, confirming there is a link between the crimes.[124] Swart argues that the principle of universal jurisdiction could have been implemented[125] and that a duty rests upon the National Prosecuting Authority to prosecute international crimes. Yet international customary law fails to address this very point.[126]

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119 *Ibid.*

120 International Convention on the Suppression and Punishment of the Crime of Apartheid, 30 November 1976 A/RES/3068(XXVIII).

121 Heads of argument Adv Trengove SC in *S v Basson* 2005 (12) BCLR 1192 (CC) 90 – 96.

122 Swart 219.

123 S v Basson 227.

124 *Idem* 228. This would have rendered the comity principle fruitless for the defence.

125 Swart 220 – 222.

126 *Idem* 222.

It seems the author has not taken cognisance of the general amnesty which was granted to members of the SADF who operated in Namibia prior to 1989, as mentioned above. In my view, the general amnesty in any event renders prosecution doubtful as it explicitly indemnifies members of the SADF for their actions and would have led to an acquittal.[127]

In light of the above it is evident that Basson was fortunate that as a result of the excellence of his defence he was acquitted on the charges. Nevertheless, it should be noted that had the prosecution called several additional witnesses to corroborate some of the testimony and if they had taken cognisance of international law principles in drafting the indictment, an acquittal might have been more difficult.

Acquittal of the criminal charges is not the end of the story. As a member of the Health Professions Council of South Africa he is subject to their code of conduct and as the criminal trial came to an end his professional trial commenced.

4.6 Basson's HPCSA disciplinary hearings[128]

The HPCSA's investigations into Basson's alleged misconduct commenced in 2006 and the first formal charge sheet was put to Basson in 2007. The disciplinary inquiry into Basson's conduct began in November 2007.[129]

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127 Administrator-General Government Notice, No. 16 of 1990.

128 It must be recorded at this stage that the transcription of the disciplinary hearing prior to sentencing is unavailable. According to the HPCSA the transcriber contracted to transcribe the hearing at the time, disappeared after one of the postponements with all the documentation and they were unsuccessful in locating the transcriber after that date. Those records are unobtainable.

129 https://www.iol.co.za/news/politics/trc-evidence-at-basson-hearing-1547820#.UeV3To2mh3p. The charges were laid against Basson by more than 40 doctors in 2007. https://citizen.co.za/news/south-africa/281620/heard-hpcsa-dr-wouter-basson-struck-roll/. It also appears as if Section 27 was part of the complainants.

The charge[130]of unprofessional conduct whilst being a registered medical practitioner brought against Basson related to his involvement in Project Coast but he was acquitted on charges 1, 2.1 and 3 that related to illegal research. The charges which remained are the following:[131]

That he is guilty of unprofessional conduct, as defined in section 1 of the Health Professions Act 56 of 1974, in that:

Charge 2:

2.2 During or about the period 1986 to 1988 and 1992, as project officer of Delta G, he coordinated the production of the following drugs and teargases on a major scale:

2.2.1 Methaqualone -

Also known as Mandrax,[132] which is a sedative drug. The usual effects include relaxation, euphoria and drowsiness, also reducing the heart rate and respiration.

Larger doses can cause depression, a lack of muscular coordination and slurred speech.

An overdose can cause delirium, convulsions, hypertonia, hyperplexia, vomiting, renal insufficiency, coma and death through cardiac or respiratory arrest.'

2.2.2 MDMA -

Also known as Ecstasy and referred to in the criminal trial as "Baxil".

It is a semi-synthetic entactogen of the phenethylamine family considered a recreational drug.

The effects are subjective feelings of openness, empathy, energy, euphoria and wellbeing.

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130 These charges derive from Basson's testimony under oath during the criminal trial proceedings.

131 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo). See also transcription 26 November 2014 line 11 page 3.

132 Transcription 26 November 2014 line 1 page 19.

Common side effects are jaw clenching and elevated pulse. Short- term health consequences include hypertension, dehydration and hyperthermia.'

2.2.3 BZ -

BZ is an incapacitating agent.

Approximately thirty (30) minutes after exposure to a BZ aerosol, symptoms appear such as disorientation with visual and auditory hallucinations.

The symptoms peak and fall to eight (8) hours, and may take up to four (4) days to pass.

Other symptoms can include distended pupils, dry mouth and increased body temperature. The action of BZ on the central nervous systems resembles that of atropine. Like atropine, BZ binds to muscarinic acetylcholine receptors.

2.2.4 CS -

CS is a teargas which causes the eyes to sting and water. CS is rapidly hydrolysed in water.

2.2.5 CR -

CR is an eye irritant (teargas), more potent but less toxic than CS. CR is hydrolysed only to a negligible extent in water solution.

Charge 4:

4.1 During the 1980s as Project Officer of Project Coast and on the direct instructions of the Chief of the South African Defence Force he was involved in weaponising thousands of 120 mm mortars with teargas; and/or

4.2 During the 1980s he had some 120 mm mortars filled with CR, referred to in paragraph 2.2.5 above, which mortars were supplied by the South African Defence Force to one Savimbi in Angola for use.

Charge 5:

During or about 1983 to 1989 he on two to four occasions provided disorientation substances for over-the-border kidnapping (‘grab') exercises, where the substances were used to tranquilise the person to be kidnapped.

Charge 6:

During 1982 to 1989 he made available cyanide capsules to operational officers commanding for distribution to members of specialised units for suicidal usage. It is also alleged that a number of protocols, codes, conventions and regulations would be identified as being the ethical rules relied on.[133]

In essence, the charges before the HPCSA are that while registered as a medical practitioner with the HPCSA and its predecessor Basson is guilty of unprofessional behaviour because he was the head of a project which manufactured chemical substances for warfare, as well as the weapons and provided their use in combat, and assisted in kidnappings and suicide.[134]

Basson maintained his innocence throughout the inquiry, which was delayed several times due to the illness of witnesses as well as several interlocutory applications brought by Basson during 2008, 2010, 2011 and 2012 to expunge the hearing and charges against him with little success.[135] Consequently, the hearing dragged on for five years as a result, as well because the expert witness on behalf of the HPCSA, Professor Benatar, made several concessions which led to the prosecution to request a postponement to obtain a new expert witness to testify.[136]

In order to substantiate the charges the prosecution called four witnesses to testify. Professor Benatar, a medical specialist, purported to be an expert in the field of medical ethics.[137] In his opinion, Basson under oath had admitted to contravention of several conventions and ethical rules during his criminal trial.[138] Benatar's evidence was

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133 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (accessed on 2 September 2018) (written by Prof Jannie Hugo).

134 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (accessed on 2 September 2018) (written by Prof Jannie Hugo). See also transcription 26 November 2014 line 10 page 50.

135 https://www.iol.co.za/news/politics/trc-evidence-at-basson-hearing-1547820#.UeV3To2mh3p.

136 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo).

137 *Ibid.*

138 *Ibid.*

discredited by counsel for Basson and led to a postponement to find a new expert witness on behalf of the prosecution.[139]

Professor Miles, a professor of Medicine at the University of Minnesota Medical School and the Minnesota Center for Bioethics in Minneapolis, USA, and was affiliated to the Center for Genocide and Holocaust studies and a Law School Concentration in Health Law and Bioethics was called to testify as the new expert witness on behalf of the prosecution.[140] The committee accepted his testimony as wholly reasonable and professional and it concurred with the relevant conventions of the World Medical Association.[141]

In his defence Basson first called on General Knobel, the erstwhile Surgeon-General of the Defence Force, to testify on his behalf.[142] Knobel was of the opinion that the conventions referred to by Professor Miles merely were guidelines which ought to be interpreted in line with the circumstances and the era during which Basson operated and that Basson's conduct could not be seen as a contravention of those conventions.[143] Dr Muller, a toxicologist, was called to testify as to the harmful effects of the chemical substances that allegedly were produced under Basson's supervision.[144] The crux of his testimony was that one would require some medical knowledge in order to conduct research on the substances listed in the charge sheet but that medical training is insufficient to equip one to conduct in-depth research into those substances.[145]

The Disciplinary Committee accepted that as the project officer of Project Coast, Basson coordinated the stockpiling and production of chemical weapons on a large scale as claimed in the charge sheet.[146] Further, that on direct instruction from the Chief of the SADF he was involved in filling 120mm mortar shells with teargas to supply

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139 *Ibid.*
140 *Ibid.*
141 *Ibid.*
142 *Ibid.*
143 *Ibid.*
144 *Ibid.*
145 *Ibid.*
146 *Ibid.* Charge 2.2.

UNITA soldiers,[147] that he supplied tranquilising substances to facilitate cross-border kidnappings[148]and cyanide capsules were made available to operational officers apparently to commit suicide.[149]

According to the Committee Basson violated the following declarations and a convention:[150]

a) World Medical Association: Declaration of Geneva – Physician's Oath

   i. At the time of being admitted as a member of the medical profession:
      1. I will maintain the utmost respect for human life from the time of conception, even under threat;
      2. I will not use my medical knowledge contrary to the laws of humanity.[151]

b) World Medical Association: Regulations in Time of Armed Conflict

   i. Medical ethics in the time of armed conflict is identical to medical ethics in the time of peace .... The primary obligation of the physician is his professional duty; the physician's supreme guide is his conscience.
   ii. The primary task of the medical profession is to preserve health and safe life. Hence it is deemed unethical for physicians to:
      1. give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable in the patient's interest;
      2. weaken the physical or mental strength of a human being without therapeutic justification; and
      3. employ scientific knowledge to imperil health or destroy life.
      and
   iii. Privileges and facilities afforded to the physician must never be used for other than professional purposes.[152]

c) World Medical Association: Declaration of Tokyo – Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment.

   i. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading

147 *Ibid.* Charge 4.

148 *Ibid*. Charge 5.

149 *Ibid*. Charge 6. See also transcription 26 November 2014 line 10 page 61.

150 *Ibid.*

151 World Medical Association Declaration of Geneva (1948).

152 World Medical Association Regulations in Times of Armed Conflict (1956 & 1983).

procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations including armed conflict and civil strife.

ii. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.[153]

d) Convention on the Prohibition of the Development, Production and Stockpiling of Bacterial (Biological) and Toxin Weapons and on their Destruction:

i. Article 1:
   1. Each State Party to this convention undertakes never in any circumstances to develop, produce, stockpile or otherwise acquire or retain:
      a. Microbial or other biological agents, toxins whatever their origin or method of production, of types and in quantities that have no justification for prophylactic, protective or other peaceful purposes;
      b. Weapons, equipment or means of delivery designed to use such agents or toxins for hostile purposes or on armed conflict.[154]

Basson presented a total of nine different defences to the charges of unprofessional conduct, which are dealt with individually below:[155]

- *The alleged unprofessional conduct happened during a specific war and conflict situation.*

In his plea explanation Basson presented the circumstances of the war in Namibia and Angola as well as the situation in South Africa.[156] The alleged use of chemical weapons against UNITA forces convinced the SADF to launch Project Coast, as General Knobel had testified in two forums.[157] However, article 1 of the WMA Regulations in Times of

153 World Medical Association Declaration of Tokyo (1975).

154 Convention on the Prohibition of Development, Production and Stockpiling of Bacterial and Toxin Weapons and on their Destruction (1975).

155 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo). See also transcription 26 November 2014 line 19 page 50.

156 *Ibid.*

157 *Ibid.*

Armed Conflict states clearly that medical ethics are the same in times of peace and war.[158] It is evident that the Committee would reject this defence.[159]

- *Basson was under military instruction and supported by senior doctors.*

It was common cause among the parties that Basson received orders from his military superiors as well as from senior doctors such as Generals Knobel and Nieuwoudt, both of whom had been Surgeon-General during Basson's tenure.[160] Basson averred that Nieuwoudt would not issue unethical or illegal orders and confirmed that Nieuwoudt instructed that no deadly substances were to be developed.[161] The defence of "only obeying orders" failed in light of the evidence mounted against Basson. He had not objected to the orders given him and the logical inference is that he agreed with the substance of the orders.

- *Basson committed the acts in his capacity as a soldier and not as a doctor.*

This defence was crucial. At the disciplinary hearing he testified that his concern was as a medical doctor and not as a soldier in contradiction to his defence during the criminal trial of acting as a soldier.[162]

Basson was appointed in his capacity as a medical doctor to 7 Medical Battalion before he commenced work on Project Coast. This fact in conjunction with the reality that he had a master's degree in physiological chemistry clearly indicates why he was appointed to the position, what purpose he served and in what capacity.

The HPCSA held that for this defence to succeed Basson ought to have deregistered as a medical practitioner and had used his medical knowledge to execute orders which he argued relieved him of his duty to medical ethics.[163] This defence was dismissed.[164]

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158 World Medical Association Regulations in Times of Armed Conflict (1956 & 1983).

159 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo).

160 *Ibid.*

161 *Ibid.*

162 *Ibid.*

163 *Ibid.*

164 *Ibid.*

I submit that if Basson had deregistered as a medical practitioner and then carried out the orders related to Project Coast, after he was discharged from the military and then re-registered with the HPCSA they would have charged him with unethical conduct. Once the information of his activities came to light they would hold that he used his medical knowledge to conduct the research he was ordered to perform. He cannot dissociate himself from the knowledge he has in his capacity as a soldier.

I submit this defence ought to have succeeded on the grounds he acted in a research or scientific capacity and did not treat patients to carry out the research and did not conduct the research on human subjects. In the circumstance that Basson acted in his capacity as a scientist it raises the question whether the HPCSA has the required *locus standi* to prosecute him.

- *Basson acted as a military doctor and ethics for military doctors are different from those of civilian doctors.*

In presenting this defence, Basson stated that he had no contact with the "target", that they were not his patients and that his concern was for the citizens of South Africa.[165] This argument is supported by General Knobel's testimony that war-time medical ethics differ from medical ethics in times of peace as the doctor does not have exclusive autonomy when executing his duties and that circumstances must be taken into account.[166]

Article 1 of the WMA Regulations in Times of Armed Conflict[167] states clearly that medical ethics in times of peace and war are the same and South African military doctors are bound by the same ethical rules as civilian doctors.[168] This defence rightly was dismissed.[169]

To a certain extent the argument that the circumstance in which a military doctor executes his or her duty must be taken into account when considering the ethical

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165 *Ibid.*

166 *Ibid.*

167 World Medical Association Regulations in Times of Armed Conflict (1956 & 1983).

168 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo).

169 *Ibid.*

implications of their conduct is supported. However, Basson had difficulty in convincing the Committee that his circumstances must be taken into account as he worked in an office in Pretoria and not at the frontline where the argument may have some value.

- *The recipients of the substances were not Basson's patients and there was no doctor-patient relationship.*

Technically, this defence holds water but in substance the argument is problematic. It seems to stem from General Knobel's testimony that no doctor-patient relationship exists in military exercises developed in order to protect one's forces.[170] Nevertheless, it would be a struggle for the argument to carry conviction as Basson indirectly used his medical knowledge to inflict harm.

Also, in terms of the Tokyo Declaration[171] doctors shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations including armed conflict and civil strife. Furthermore, medical knowledge may not be used in contravention of the laws of humanity. Basson's actions violate the latter principle, directly or indirectly and this defence is dismissed.[172]

- *Basson was a young doctor at the time and therefore cannot be held responsible.*

Basson presented the argument that he was a young and inexperienced doctor when the alleged violations were committed.[173] This argument was still-born as medical interns are held to the same ethical rules as experienced doctors. Secondly, Basson was a registered specialist physician at the time that he was recruited for Project Coast and would not have been put in charge of such an important and clandestine project if

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170 *Ibid.*

171 World Medical Association Declaration of Tokyo (1975).

172 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo).

173 *Ibid.*

he was immature and did not have the necessary ability to manage the project.[174] Consequently, this defence was dismissed.[175]

- *Basson was not aware of the Codes and Conventions that forbid chemical weapons and use of medicine for non-therapeutic purposes.*

Basson and General Knobel testified that at the time they were unaware of the conventions applicable to their conduct.[176] This argument is flimsy as ignorance of the relevant conventions cannot be accepted as a defence. Basson and Knobel are highly-educated people and high-ranking functionaries of the military.

The International Code of Medical Ethics[177] states it is deemed unethical for a doctor to weaken the mental and/or physical condition of a human being without therapeutic justification and to use his or her medical knowledge to the detriment of health or life.[178] The Tokyo Declaration[179] states that the utmost respect for human life must be maintained even under threat, and that medical knowledge may not be used in contravention of the laws of humanity. The Geneva Declaration[180] states that doctors must maintain the utmost respect for human life and will not use medical knowledge to the detriment of human rights even under threat. The Biological Weapons Convention[181] provides that member parties are not allowed to produce or stockpile such weapons unless they have prophylactic justification or for peaceful purposes.

Basson violated the provisions of these conventions and/or declarations and even if only guidelines they ought to be adhered to for the sake of humanity.[182] In consideration of the grave implications attached to chemical and biological weapons, from the outset those involved in research into and/or production (as is the case here) ought to

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174 *Ibid.*

175 *Ibid.*

176 *Ibid.*

177 World Medical Association International Code of Medical Ethics (2006).

178 *Idem* paragraph 2.

179 World Medical Association Declaration of Tokyo (1975).

180 World Medical Association Declaration of Geneva (2006).

181 Convention on the Prohibition of Development, Production and Stockpiling of Bacterial and Toxin Weapons and on their Destruction 26 March 1975, 1015 UNTS 163 .

182 http://www.politicsweb.co.za/archive/dr-wouter-basson-the-hpcsas-professional-conduct-c (written by Prof Jannie Hugo).

familiarise themselves with the relevant legislative material and ensure compliance. The Committee dismissed this defence.[183]

- *Medical ethics in the 1980s differed from medical ethics today.*

Basson argued that ethical perceptions in the 1980s are different from modern ethical perceptions.[184] To a limited extent the observation is accurate with regard to experiments on new medicines, but is irrelevant in relation to the charges. Basson's conduct must be measured against his ethical duty to uphold the Hippocratic Oath and to comply with the provisions of the abovementioned declarations.

The Committee rejected this defence on what appears to be political grounds as a result of their declaration that many medical professionals remained true to the profession by rejecting conscription. The suggestion is that Basson acted unethically by being conscripted into the army despite legislation which made it compulsory.[185] This view creates an impression of considerable bias on the part of the Committee.

Nevertheless, Basson cannot rely on this defence in terms of the doctor-patient context as ethical principles in relation to chemical and biological weapons remained constant during his tenure at Project Coast.

- *The chemical substances in consideration were designed to be non-lethal to protect life.*

Basson raised this defence in a final attempt to avoid liability. He argued that these substances were designed to weaken and disorientate people, but not to kill them.[186] Apparently, the purpose was to reduce the number of fatalities, *inter alia,* in dealing with unruly gatherings in the townships.[187]

In raising this defence Basson effectively admitted guilt to charge 5 (the rendition substances) by declaring that he used his knowledge of medicine to provide substances to the armed forces to assist them in cross-border operations in which suspects were

183 *Ibid.*
184 *Ibid.*
185 *Ibid.* See also transcription 12 March 2015 line 6 page 242 and 12 March 2015 line 10 p 242.
186 *Ibid.*
187 *Ibid.* See also Gould 18 and transcription 26 November 2014 line 5 p 20.

kidnapped and interrogated.[188] The CR gas produced under his supervision caused asphyxiation.[189] If the argument relies on the claim he only oversaw the production of the substances on instruction from his superiors and acted in a scientific research capacity and not as a doctor, it may have limited validity. In any case the reality is he could not determine the application of the substances in the field and he could only make recommendations with regard to the effect.

This defence failed in respect of charge 6 (production of cyanide capsules) as the capsules had been kept in his office, were offered on sale by front companies of the SADF and allegedly were provided to SADF operators for use in case of capture. The last allegation was not proven nor could it be shown that he distributed the capsules.[190]

This defence was dismissed[191] but in my view it has merit as he did not provide the capsules to SADF operators and the alleged distribution was not proved. In the event that the alleged distributors of the capsules to SADF operators are medical practitioners, recourse lies with them and not against Basson.

Basson was found guilty of unprofessional conduct on charges 2.2, 4, 5 and 6.[192] The hearing was postponed for sentencing to November 2014 but was extended to January 2015 as a result of the complainants' untimely decision to submit a petition signed by various medical practitioners that Basson be struck from the medical roll and abrupt presentation of new testimony.[193]

Basson's legal team subsequently received information that two members of the committee, professors Hugo and Mhlanga, were members of the South African Medical Association which in December 2014 had called for Basson to be struck from the roll.[194]

Basson launched an urgent application for leave to apply for the recusal of these members. The application was granted.[195] During the next hearing in March 2015 the

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188 *Ibid.*

189 *Ibid.*

190 *Ibid.* See also Gould 61.

191 *Ibid.*

192 *Ibid.* See also transcription 27 November 2014 line 9 page 148.

193 https://mg.co.za/article/2014-11-27-basson-sentencing-begins.

194 https://www.iol.co.za/news/south-africa/gauteng/basson-uses-loophole-to-delay-sentencing-1865040.

two members refused to recuse themselves and the matter was postponed to May 2015 for sentencing arguments.[196] As a result of their refusal Basson launched a review application in May 2015 citing suspected bias on the part of the two members, which bias infringed his right to a fair trial.[197]

The application was dismissed in 2016 by the Pretoria High Court for not first exhausting his internal remedies at the HPCSA.[198] Basson successfully petitioned the Supreme Court of Appeal in 2017 which unanimously set aside the High Court Order citing exceptional circumstances within the meaning of section 7(2) of PAJA.[199] The court stated *inter alia:*

> The rule against bias is entrenched in the Constitution, which places a high premium on the substantive enjoyment of rights (*Koyabe* supra para 44). Section 38 of the Constitution gives the appellant the right to approach a competent court if a right in the Bill of Rights (s 34) has been infringed or threatened, and the court may grant appropriate relief. In ruling against the appellant, the Committee has set out its position and there is a proper record of the proceedings before it. If the relevant members of the Committee should have recused themselves, the proceedings before it would be null and void; and any appeal to an appeal committee would suffer the same fate. The pursuit of an internal remedy would therefore be futile.[200]

The matter was remitted to the High Court for determination of the review application. On 27 March 2019 the High Court delivered its judgment and granted the relief sought by Basson.[201] The court remarked that during the disciplinary hearing Basson had requested that these members confirm whether in fact they are members of SAMA but that request was refused and no further explanation was provided.[202] Basson requested a postponement in those circumstances for them to consider their position and if necessary to approach the High Court on an urgent basis for an interdict prohibiting the

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195 *Ibid.* See also transcription 12 March 2015 line 5 p 2 and line 10 p 242.

196 *Ibid.*

197 In my view this application ought to have succeeded at first hearing. The argument of suspected bias was well founded and could have been avoided by the HPCSA if they had better managed the situation.

198 https://www.timeslive.co.za/news/south-africa/2018-01-17-basson-wins-challenge-on-professors-deciding-his-sentence-for-misconduct/.

199 Promotion of administrative justice Act 3 of 2000.

200 *Basson v Hugo & Others* (2018) 1 All SA 621 (SCA) 27.

201 *Dr Wouter Basson v Professor JFM Hugo & 2 others* (GP), case number 29967/2015 [38].

202 *Idem* [9].

hearing from proceeding.[203] That request also was denied. Basson requested that his right to cross-examine the prosecution's witness, Prof Blockman, be reserved but again that was denied.[204]

In the circumstances various successful interim urgent applications by Basson ensued.[205] The court found that the deliberate non-disclosure of SAMA membership and no disassociating declaration from the SAMA petition led to a reasonable suspicion of bias. It is not unreasonable to infer that Professor Hugo refused to disclose his membership because he supported the contents of the petition.[206] On its own this behaviour is reason enough to review and set-aside their refusal to recuse themselves.[207] The court further considered the refusal to grant Basson a postponement to consider his position and to institute an urgent application interdicting the committee from proceeding with the hearing. The court remarked that the refusal to grant a postponement and to proceed with the evidence of Prof Blockman *in absentia* to be "astounding".[208] The court found this action to be procedurally irregular and substantively unfair.[209] Counsel for the HPCSA and the prosecutor in the disciplinary hearing, conceded that this was substantively unfair and undertook that the committee would not object to recalling Prof Blockman to allow Basson to cross-examine him.[210] The court remarked that "this correct concession confirms the irregularity and unfairness of the process illustrating a total disregard for the rights of Basson constituting a reasonable apprehension of bias in a reasonable person".[211]

The court decided not to consider the other grounds for review as a case was already made to grant the relief sought.[212] However, the court did make an *obiter* remark regarding the fact that the firm of attorneys who had appointed the *pro forma*

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203 *Ibid.*
204 *Idem* [10].
205 *Idem* [11] – [14].
206 *Idem* [31].
207 *Idem* [32].
208 *Idem* [34].
209 *Ibid.*
210 *Ibid.*
211 *Ibid.*
212 *Idem* [35] – [36].

prosecutor represented also the committee members in the high court proceedings. In other words, they were acting on behalf of the prosecution and the committee at the same time, which suggests a conflict of interest. The court remarked that "the appointment of the same attorney is just another one of the comedy of errors unfortunately constituting facts for reasonable bias".[213] Basson succeeded in his review application and obtained the following order:[214]

i. The refusal of Professors Hugo and Mhlanga to recuse themselves from the disciplinary proceedings against Basson is reviewed and set aside;
ii. Professors Hugo and Mhlanga are ordered to recuse themselves from the disciplinary proceedings against Basson;
iii. The HPCSA is ordered to pay the costs of the application.

Basson had been granted a further delay to hearing his fate as the entire disciplinary process must commence *de novo* before a new committee. The delay could be even longer as most likely all the evidence must be presented again. I submit the ruling in the High Court most likely will not be the end of the matter. The entire hearing is now tainted and open to further review and special pleadings by Basson.

The HPCSA is criticised for its stubborn approach to Basson's request for recusal. The request should have been granted as there is a clear argument with regard to bias as Professors Hugo and Mhlanga are members of SAMA and had called for Basson to be struck from the roll. Further, the committee had presented a subjective opinion in its comments about doctors who served in the military during the 1980s. These are sufficient grounds for the automatic disqualification of the two members and for the matter to have been remitted to a new committee.[215] The matter could have been dealt with since then, but the HPCSA effectively played into the hands of Basson (who appears to be in no hurry to finalise this matter) by refusing the request for recusal of the members. Consequently, a cloud of bias surrounds any further disciplinary proceedings.

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213 *Idem* [37].

214 *Idem* [38].

215 Transcription 12 March 2015 line 15 page 243. See also Dr Wouter Basson v Professor JFM Hugo & 2 others (GP) [33].

A travesty of justice has resulted in vilification and has produced open hostility among the parties. In light of the above, it is submitted that the proceedings raise constitutional implications especially in terms of the rights to equal treatment before the law[216] and to be granted a fair trial.[217]

4.7 Conclusion

In light of the above medical professionals who find themselves on the wrong side of their ethical responsibilities pay a high price for their wrongdoing. The actions of Basson differ in degree from the behaviour of doctors under National Socialism such as Dr Karl Brandt. Basson's research into and the production of CBW is on a different scale to the experimentation conducted under National Socialism. Basson contravened his ethical obligations in being aware of the fact that the CBW was produced despite the adoption of the Biological and Chemical Weapons Conventions by the South African government. It is difficult to accept that Basson was oblivious of the fact that South Africa has ratified the aforesaid conventions. In my view he cannot rely on that defence.

Despite the ruling by the HPCSA against Basson, the future consequences of this sanction are uncertain. The *entire* hearing may have to recommence *de novo* or only the sanctioning hearing. I submit that even if the sanctioning hearing proceeds before a new committee, Basson will be entitled to institute another review application setting aside his conviction based on the judgment of the successful recusal application. It follows that if the refusal to recuse was set aside based on a reasonable apprehension of bias, the conviction reasonably is susceptible to a court challenge.[218] However after establishing that Basson transgressed his ethical obligations as a medical practitioner it is unlikely that the HPCSA will abandon the prosecution in its entirety. It cannot be predicted what the sanction will be but it is probable that the HPCSA will seek the permanent removal of his name from the register of medical practitioners.

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216 S 9 of the Constitution, 1996.

217 S 35(5) read with s 33 and 34 of the Constitution, 1996.

218 It is unknown whether the respective legal teams had an arrangement confirming that if the review application succeeds then the entire hearing must commence *de novo* or not.

The ruling in the High Court may not end the matter of the review proceedings as the HPCSA may approach the Supreme Court of Appeal to obtain the relief sought and if unsuccessful may resort to the Constitutional Court.

In the next chapter I examine the legislative framework which pertains to the medical profession in South Africa.

CHAPTER 5

MEDICAL PROFESSIONALS IN SOUTH AFRICA:

DR BASSON AND MUNICIPAL LAW

5.1 Introduction

The previous chapter described Dr Basson's career, his criminal trial and the disciplinary process instituted by the HPCSA. In this chapter the legislative framework within which medical professionals in South Africa function is examined, beginning with the Health Professions Act 56 of 1974 (as amended) (HPA).

5.2 Health Professions Act 56 of 1974 (as amended)

The HPA came into effect on 21 February 1975, Basson at that time had not qualified therefore the HPA applies to Basson's conduct after he became a specialist physician. The HPA established the Health Professions Council of South Africa (HPCSA) and confers its powers upon it in terms of sections 2 to 15B thereof. The objectives and functions of the HPCSA are contained in section 3, subsections of which are highlighted below:

> 3(b) to promote and to regulate inter-professional liaison between health professions in the interest of the public;
> (j) to serve and protect the public in matters involving the rendering of health services by persons practising a health profession;
> (m) to uphold and maintain professional and ethical standards within the health professions;
> (n) to ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action is taken against such persons in accordance with this Act in order to protect the interest of the public;
> (o) to ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly; …

The mandate of the HPCSA is to regulate the relationship between medical professionals and their patients, and for that purpose to conduct disciplinary procedures against medical professionals. The HPCSA performs its disciplinary hearings by

establishing a professional conduct committee in accordance with section 10(1) and, should the need arise, an appeal committee in terms of section 10(2). The appeal committee either confirms the decision of the committee *a quo,* sets it aside or remits the matter back to the committee *a quo* with further instructions as it deems fit.[1] The decisions of both committees are effective from a date determined by the specific committee.[2] The accused can take their decisions on review to the High Court if he or she feels aggrieved by the outcome.

Professional boards are at liberty to register and suspend practitioners from practicing pending the institution of a formal enquiry in terms of section 41.[3] Formal inquiries are instituted by professional boards[4] for allegations of unprofessional conduct by a registered member.[5] Penalties may be imposed upon the member as contemplated in section 42. Should the need arise the registrar of the HPCSA may appoint an investigating officer to obtain more information in order to conduct a proper disciplinary hearing.[6] The investigating officer has a broad spectrum of powers extensively outlined in the HPA, including the liberty to obtain a search warrant before a judge or magistrate to execute his duties.[7] The investigating officer is obliged to compile a confidential report in respect of his findings, which shall be deemed to be a complaint in the event that *prima facie* evidence is presented and a complaint of unprofessional conduct has not been lodged formally.[8]

Section 42 deals with procedure in relation to inquiries and the imposition of penalties. It states that any registered member found guilty by a preliminary committee of minor transgressions or found guilty of improper or disgraceful conduct by a professional conduct committee may suffer one of the following penalties:

(a) either a caution, reprimand, or both; or

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1 S 10(3).
2 Ss 10(4) and (5).
3 S 15B.
4 Established in terms of s 10.
5 S 41.
6 S 41A(1) – (4).
7 S 41A(6).
8 S 41A(8).

(b) suspension from practice for a certain period; or

(c) removal of the accused's name from the register; or

(d) a fine; or

(e) compulsory period of professional service determined by the professional board; or

(f) payment of costs of proceedings, restitution or both.[9]

In the event that an appeal is lodged against a removal or suspension from practice the penalty remains in effect until the penalty is set aside.[10] An inquiry convened in terms of section 41 affords the accused the right to legal representation,[11] and they may obtain evidence under oath and subpoena witnesses to testify or produce certain documents.[12] In the event that a professional board finds the accused guilty of unprofessional conduct it may issue summons against the accused and the accused has an option to pay an admission of guilt fine without appearing at the inquiry.[13] A penalty imposed by the professional board has the same effect as a civil judgment obtained against the accused in the magistrates' court.[14] The professional board may impose a suspended penalty during which time the accused must adhere to certain conditions.[15]

If the accused has complied with the conditions, the board has the discretion to inform him that no further penalties will be imposed or that the penalty will not be executed in part or completely.[16] Alternatively, if the accused violates the conditions set out by the board, the board is entitled to execute part or the entire penalty unless the accused can prove that the conditions were violated due to circumstances beyond his control.[17]

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9 S 42(1).

10 S 42(1A).

11 S 42(2).

12 S 42(4).

13 S 42(8).

14 S 42(10).

15 S 43(1).

16 S 43(2)(a) and (b).

17 S 43(2)(c).

Should the board find that suspension from practice or removal from the register is the appropriate sanction *ipso facto* that person is barred from practising and his registration certificate is deemed to be cancelled until such time that the suspension has expired or his name has been restored to the register by the professional board.[18]

The professional board is at liberty to charge a member with unprofessional conduct if the member has been convicted of an offence by a court of law which, according to the board, constitutes unprofessional conduct.[19] If, during proceedings in court, it appears that there is *prima facie* proof of unprofessional conduct on the part of a member, the court shall order that a copy of the record of proceedings (or judgment) be forwarded to the professional board.[20] Recently, there has been a proliferation of unregistered laymen impersonating doctors[21] despite there being severe sanctions against such conduct including a fine and/or imprisonment for a period not exceeding five years.[22]

Section 49 of the HPA states that the HPCSA is entitled to make rules specifying acts or omissions in terms of which the professional boards may take disciplinary steps.[23]The Ethical Rules of Conduct for Practitioners Registered under the HPA[24] contain 28 rules to which medical professionals must adhere, some of the rules are reflected below.

i. Rule 20 – Defeating or obstructing the council or board in the performance of its duties:

   The rule states as follows:

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18 S 44.

19 S 45(1).

20 S 45(2).

21 https://www.dfa.co.za/south-african-news/bogus-doctors-arrested-in-limpopo. https://www.iol.co.za/news/south-africa/limpopo/limpopo-cops-nab-two-for-impersonating-police-13576955. https://www.news24.com/SouthAfrica/News/bogus-doctor-sentenced-to-20-years-imprisonment-20170825 (accessed on 17 December 2018).

22 S 40.

23 This section must be read in conjunction with s 61(2) and 61A(2).

24 Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act 56 of 1974 (as amended).

A practitioner shall at all times cooperate and comply with any lawful instruction, directive or process of the council, a board, a committee of such board or an official of council and in particular, shall be required, where so directed to –

(a) respond to correspondence and instructions from the council, such board, a committee of such board or an official of council within the stipulated time frames; and

(b) attend consultation at the time and place stipulated by the council, such board, a committee of such board or an official of council.[25]

This rule is of specific application in the case of disciplinary procedures against members of the HPCSA. The cooperation of members in this regard ensures a transparent and accountable process whereby the HPCSA can fulfil its mandate. It is in the member's interest to cooperate with the HPCSA at all reasonable times as an obstructive approach towards the investigation gives the impression that a member has something to hide or is covering his or her tracks. Basson appears to have cooperated with the HPCSA in their investigation even though much evidentiary material could have been obtained from the criminal trial in which the facts were covered thoroughly.

ii. Rule 23 – Medicine and medical devices:

(1) A practitioner shall not participate in the manufacture for commercial purposes or in the sale, advertising or promotion of any medicine or medical device or in any other activity that amounts to selling medicine or medical devices to the public or keeping an open shop or pharmacy.

(2) A practitioner shall not engage in or advocate the preferential use or prescription of any medicine or medical device which, save for the valuable consideration he or she may derive from such preferential use or prescription, would not be clinically appropriate or the most cost-effective option.

(3) The provisions of sub-rules (1) and (2) shall not prohibit a practitioner from –

(a) owning shares in a listed company;

(b) manufacturing or marketing medicines whilst employed by a pharmaceutical concern;

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25 *Ibid* 17.

(c) whilst employed by a pharmaceutical concern in any particular capacity, performing such duties as are normally in accordance with such employment; or

(d) dispensing in terms of a licence issued in terms of the Medicines and Related Substances Act, 1965.

(4) A practitioner referred to in sub-rule (3) shall display a conspicuous notice in his or her waiting room and also duly inform his or her patient about the fact that he or she–

(a) owns shares or has a financial interest in a listed public company that manufactures or markets the medicine or medical device prescribed for that patient; or

(b) is in the employ of or contractually engaged by the pharmaceutical or medical device company that manufactures such medicine or medical device, and shall, subject to sub-rule (5), obtain the patient's informed written consent prior to prescribing such medicine or medical device for that patient.

(5) A practitioner may prescribe or supply medicine or a medical device to a patient: Provided that such practitioner has ascertained the diagnosis of the patient concerned through a personal examination of the patient or by virtue of a report by another practitioner under whose treatment the patient is or has been and such medicine or medical device is clinically indicated, taking into account the diagnosis and the individual prognosis of the patient, and affords the best possible care at a cost-effective rate compared to other available medicines or medical devices and the patient is informed of such other available medicines or medical devices.

(6) In the case of a patient with a chronic disease the provision of sub-rule (5) shall not apply.[26]

It was alleged that Basson and/or his team dispensed certain medicines from the production facilities and/or Speskop to special-forces members of the defence force. These medicines were not necessarily clinically appropriate nor did they provide the best possible care to the people to whom they were administered, for example, the provision of cyanide capsules for alleged self-use in the event of being captured by the enemy. At his trial no definitive proof was provided in respect of the charge.

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[26] *Idem* 17 – 18.

iii. Rule 25 – Reporting of impairment or of unprofessional, illegal or unethical conduct:

(1) A student, intern or practitioner shall –

(a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired;

(b) report his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or her own impairment or has been publicly informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment; and

(c) report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner.[27]

Basson and his colleagues were well-protected by their superiors (some of whom were medical practitioners) who knew what kind of activity they were engaged in for Project Coast and consequently were aware of the chance of illegal or unethical practices. They relied on the argument that as soldiers they merely obeyed orders and did their duty.

iv. Rule 26 – Research and development and use of chemical, biological and nuclear capabilities:

(1) A practitioner who is or becomes involved in research, development or use of defensive chemical, biological or nuclear capabilities shall obtain prior written approval from the board concerned to conduct such research, development or use;

(2) In applying for written approval referred to in sub-rule (1), such practitioner shall provide the following information to the board concerned:

(a) Full particulars of the nature and scope of such research, development or use;

(b) whether the clinical trials pertaining to such research have been passed by a professionally recognized research ethics committee;

(c) that such research, development or use is permitted in terms of the provisions of the World Medical Association's Declaration on Chemical and Biological Weapons; and

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27 *Idem* 20.

(d) that such research, development or use is permitted in terms of the provisions of the applicable international treaties or conventions to which South Africa is a signatory.[28]

Basson and his team could hardly demonstrate they complied with this rule. Evidence has not been offered to show that they had the Council's permission to conduct the research or that the Council was aware of the nature and scope of the research. It is indisputable that the research projects were conducted in contravention of the Biological Weapons Convention[29] and the Chemical Weapons Convention.[30] The substances the research produced allegedly were used on civilians and by members of the defence force *inter alia* during cross- border raids.

v. Rule 27A – Main responsibilities of health practitioners:

A practitioner shall at all times –

(a) act in the best interests of his or her patients;

(b) respect patient confidentiality, privacy, choices and dignity;

(c) maintain the highest standards of personal conduct and integrity;

(d) provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others;

(e) keep his or her professional knowledge and skills up to date;

(f) maintain proper and effective communication with his or her patients and other professionals;

(g) except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his or her next of kin; and

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28 *Ibid*.

29 Convention on the prohibition of the development, production and stockpiling of bacteriological and toxin weapons and on their destruction 26 March 1975, 1015 UNTS 163 .

30 Convention on the prohibition of the development, production, stockpiling and use of chemical weapons and on their destruction 29 April 1997, 1974 UNTS 45 .

(h) keep accurate patient records.[31]

From the evidence given during the criminal trial and at the disciplinary hearing it is clear that the recipients of the biological and chemical substances that were produced cannot be described as patients, but clearly Basson did not act in their best interests as these substances were intended to cause harm and deprived the victims of their dignity in violation of the Hippocratic Oath which states: “I will do no harm or injustice to them (patients)”.

In the administration of the substances there can be no question of informed consent as it occurred under circumstances of being kidnapped. Basson did not personally administer the substances, but it is doubtful that it constitutes exoneration.

The rules of conduct pertaining specifically to the medical and dental professions attached as annexure 6 to the Rules contain additional rules of conduct to which medical practitioners must adhere.[32] However, these additional rules are not specifically relevant to this discussion. As stated the HPCSA derives its powers from the HPA and has drafted several guidelines pertaining specifically to research into and the production of chemical and biological weapons. The guidelines are examined below.

5.3 HPCSA guidelines for good practice in the health care professions

The HPCSA issued the Guidelines for Good practice in the health care professions in a series of sixteen booklets to assist practitioners in understanding and adhering to the obligations imposed upon them by their profession and the HPCSA, as well as assisting the HPCSA in taking action against transgressors of these guidelines. Not all the booklets are relevant to the discussion but the relevant sections are referenced.

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31 *Idem* 21.

32 *Idem* 29.

5.3.1 Booklet 1: General ethical guidelines for the health care professions

This booklet focused on value-based principles and ideals to which a medical professional's conduct should adhere.[33] The principle values required from health care professionals include respect for persons, non-malfeasance, beneficence, human rights, patient autonomy, integrity, truthfulness, confidentiality, compassion, tolerance, justice, professional competence, self-improvement and community.[34]

As not every situation can be addressed fully, in the case of an ethical dilemma the practitioner ought to resort to ethical reasoning.[35] Ethical reasoning consists of four steps, namely formulating the problem, gathering information, considering options and making a moral assessment.[36] Perhaps the most important consideration should be what is referred to as *the Golden Rule*, which is how in a similar situation the medical practitioner would like to be treated.[37]

The practitioner's duty towards his patient's best interest and well-being is the most important and must be adhered to at all times.[38] Practitioners should honour their patients' trust, beliefs and criticisms and provide treatment to patients even if their condition is attributed to their own conduct.[39] At all times practitioners should respect their patients' dignity and privacy and avoid improper relations with them as well as safeguard them against human rights violations.[40] There rests a duty on practitioners to obtain informed consent from patients as far as possible, to respect their confidentiality by not making disclosures without their consent and to allow patients to take an active part in their treatment.[41]

Practitioners have a duty to report misconduct in circumstances where they believe that the rights of patients are being violated or witness unethical conduct, and to

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33 HPCSA guidelines for good practice in the health care professions, Booklet 1, (2008) 6.
34 *Idem* 2 – 3.
35 *Idem* 3.
36 *Ibid.*
37 *Ibid.*
38 *Idem* 5.
39 *Idem* 5 – 6.
40 *Idem* 6.
41 *Idem* 7.

protect patients against victimisation or intimidation.[42] In this respect Basson and his colleagues failed their responsibilities as none of them reported the violation of the rights of the targets.[43]

5.3.2 Booklet 6: General ethical guidelines for health researchers

This booklet expresses the ethical guidelines for health researchers, failure to adhere to them will result in disciplinary steps as well as other legal consequences.[44]

It is important to note the definitions of the relevant terms. A health researcher refers to all scientific investigators engaged in "health research".[45] "Health research" includes any "research which contributes to knowledge of the biological, clinical, psychological or social processes in human beings, improved methods for the provision of health services, human pathology, causes of the disease(s), the effects of the environment on the human body, the development or new application of pharmaceuticals, medicines and the development of new applications of health technology".[46]"Research ethics committee" is defined as "any committee registered in terms of section 73 of the NHA with the duty of protecting research participants through ethical review, approval and monitoring of research".[47]

Health researchers have a duty to ensure that the highest possible standards are upheld to protect study participants, to comply with the provisions of the NHA and to conduct the research in an ethical manner which contributes to science.[48] In order to conduct ethical research some core principles must be upheld, namely:

i. Well-being and best interest – this includes the principles of non-malfeasance and beneficence, as risks for participants must be minimised and the benefits of the research must outweigh the risks.

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42 *Idem* 10.

43 Gould C & Fold, P *Project Coast: Apartheid's chemical and biological warfare programme* (2002) United Nations institute for disarmament research (UNIDIR), United Nations 165 – 167.

44 HPCSA guidelines for good practice in the health care professions, Booklet 6, (2008) 1.

45 *Ibid* 1.

46 *Ibid.* See also s 1 of the National Health Act 61 of 2003 (NHA).

47 *Ibid.*

48 *Idem* 2.

ii. Respect for persons – this includes patient autonomy affording the patient the right to make informed decisions about its participation in the research and patient confidentiality.

iii. Justice – patients/participants must be treated in accordance with what is right and just. The research should not at any stage leave the participant worse off than it was before the study was initiated.[49]

These standards impose several duties on researchers in relation to the participants in their studies, including acting in their best interest, respecting participants, obtaining written and proper informed consent from the participants and if needed, on-going informed consent, maintaining participant confidentiality, remaining impartial, fair and just in conducting the research, ensuring the all-encompassing treatment is available to participants if needed and declaring, managing and avoiding any potential conflict of interest.[50]

The researcher must respect other health care practitioners in pursuit of benefit to the health care of participants, ensure that she is competent and qualified properly to conduct the research within the applicable regulatory framework and that the research equipment is up to date and in good-working condition.[51] Researchers are obliged to report scientific misconduct such as falsification of results or qualifications, inappropriate disclosure of participant information, deviation from the approved protocols and deception in research proposals.[52]

It is of utmost importance that researchers ensure that their research complies with the legal requirements and ethical guidelines, and are supervised by suitably qualified researchers and legal bodies.[53] Researchers may commence their study only once the required approval has been granted by the applicable committees and must

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49 *Idem* 2 – 3.
50 *Idem* 3 – 7.
51 *Idem* 8.
52 *Idem* 9.
53 *Idem* 10.

immediately halt their study once it is established that the research question is answered or that the research is harmful to participants.[54]

Researchers must be cautioned that data (including tape recordings) must be securely stored for at least two years after publication or for a period of six years if not published.[55] The data specimens may be transferred out of the country only once approved by the Research Ethics Committees and after a Material Transfer Agreement has been signed and submitted to the Research Ethics Committees.[56]

5.3.3 Booklet 8: Research, development and use of chemical and biological weapons.

This booklet sets out HPCSA policy with regard to the involvement of health care professionals in research into, and the development and use of chemical and biological weapons.[57] During Basson's tenure in the defence force these guidelines did not exist, they were drafted in response to the evidence of those involved in Project Coast during the Truth and Reconciliation Commission (TRC) hearings.[58]

In the event of a request to conduct research into chemical or biological weapons, health care researchers must repudiate a request in the case of research being used to harm.[59] If the researcher is coerced by the authorities to conduct such research, they must inform the HPCSA and any other professional body that can help to resist such pressures.[60] The HPCSA states that no distinction should be drawn between offensive and defensive weapons and that weapons that have the capacity to inflict harm should be regarded as offensive despite undertakings that they will be used for defensive purposes.[61]

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54 *Ibid.*
55 *Idem* 11.
56 *Ibid.*
57 HPCSA guidelines for good practice in the health care professions, Booklet 8 (2008).
58 *Idem* 1.
59 *Idem* 2.
60 *Ibid.*
61 *Ibid.*

Initially, Project Coast was presented as a defensive programme, but over the course of time the research into weapons and biological agents increasingly was directed at offensive measures and the project actively provided offensive substances to the defence force. In the circumstances it is suggested any medical professional should refer the production of these substances to another military department. Basson did not act in that manner. If the weapons are developed in order to protect members of the defence force and/or civilians against chemical and biological weapons, then such research must be subject to proper peer-review and oversight by organisations such as the HPCSA to give the appearance of ethical conduct.[62]

A health care practitioner involved in research relating to combat using chemical and biological weapons shall obtain the proper permission from the HPCSA and furnish the HPCSA with the following:

i. The full nature and scope of the envisaged research, development and use;

ii. Specify whether the research protocols have been accepted by a professionally recognised research ethics committee;

iii. Specify how the research, development and use shall be permissible with the provisions of the WMA Declaration on Chemical and Biological Weapons;[63] and

iv. Specify how the research, development and use is permitted in terms of the applicable declarations and treaties to which South Africa is a signatory;[64]

If the research is of a clandestine nature and restricts civilian access (for military safety reasons), then an ethics committee should be established by the defence force

62 *Ibid.*

63 WMA Declaration on Chemical and Biological Weapons (1990).

64 Booklet 8, 2.

authorities to provide proper ethical oversight over the chemical and biological weapons research in accordance with HPCSA guidelines and WMA Declarations.[65]

In the case of *bona fide* misuse of biological research for the purpose of creating biological agents and the researchers are unable to control the use, such research is considered "dual use", there were no offensive intentions but the findings may be used for non-peaceful objectives.[66] This situation requires an added form of oversight prior to approval of the research and encumbers health care practitioners with the responsibility to consider whether the findings of their study are open to possible abuse by the production of chemical and biological weapons.[67]

Further guidance in relation to the issues raised and the implications of the case of Basson requires attention being given to the stipulations of the Constitution,1996.[68]

5.4 The Constitution, 1996

The Constitution is supreme law and any law which is inconsistent with it is void. The rights enumerated in the Constitution must be adhered to.[69] Sections 7 to 39 of the Constitution contain the Bill of Rights and entrench the rights of all South Africans. Below some sections of the South African Constitution are examined and the implications these present are explored.

5.4.1 Section 9 – Equality:

Equality is the formal idea that that those who are similarly situated in relevant ways should be treated similarly and those not similarly situated should be treated dissimilarly.[70]According to section 9, everyone is equal before the law and has the right to equal protection and benefit of the law

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65 *Ibid*. Such committee must also consist of a qualified civilian participant with the relevant human rights and ethical expertise.

66 *Idem* 2 – 3.

67 *Ibid.*

68 Constitution of the Republic of South Africa, 1996. Also referred to as Act 108 of 1996.

69 Ss 2 and 7 of the Constitution, 1996.

70 Currie, I *The Bill of Rights Handbook* (2015) 210.

(including accused persons).[71] "Equality includes the full and equal enjoyment of all rights and freedoms, to promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken."[72]

This section guarantees that the law will protect and benefit people equally and prohibits unfair discrimination.[73] A distinction is drawn between formal and substantive equality. Formal equality means the law must treat individuals in like circumstances alike whereas substantive equality means the law must ensure an equality of outcome and be prepared to tolerate a disparity in treatment to achieve its goal.[74] Formal equality requires that all persons are equal bearers of rights and does not take into account the circumstances of the individual couched with the right in question.[75]Substantive equality examines the social and economic conditions of the bearer of the right to establish whether the Constitution's commitment to equality is upheld or not.[76] According to the Constitutional Court, section 9 must be read in terms of a substantive understanding of equality and each case must be examined on its own merits in relation to the impact of the discriminatory action upon the particular people concerned and determine whether its overall impact is one which furthers the constitutional goal of equality or not.[77]

Further, it states that past unfair discrimination and its causes must be halted as soon as possible otherwise they may continue for an indefinite period and that equality delayed is equality denied.[78] What needs to be

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71 S 9(1).

72 S 9(2).

73 Currie 211.

74 *Idem* 213.

75 *Ibid.*

76 *Ibid.*

77 *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 CC [41].

78 *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) [60] – [61].

established is when the equality clause has been violated. In *Harksen v Lane NO*[79] the court formulated an enquiry to determine whether there was a possible violation of the equality clause:

a. Does the challenged law or conduct differentiate between people or categories of people? If so, does the differentiation bear a rational connection to a legitimate government purpose? If not, then there is a violation of section 9(1). Even if it does bear a rational connection, it may still constitute unfair discrimination;
b. Does the differentiation amount to unfair discrimination? This requires a further two-stage analysis:
    i. Firstly, does the differentiation amount to 'discrimination'? If it is on a specified ground then discrimination is established. If not on a specified ground, then whether or not there is discrimination will depend upon whether objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably serious manner;
    ii. Secondly, if the differentiation amounts to 'discrimination' does it amount to 'unfair discrimination'? If it is found to be on a specified ground, unfairness will have to be established by the complainant. The test for unfairness is based on the impact of the discrimination on the complainant and others in her situation.

    If the differentiation is found not to be unfair at this stage, then there is no violation of sections 9(3) and (4).
c. If the discrimination is found to be unfair then a determination will have to be made whether the provision can be justified under the limitation clause.[80]

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79 *Harksen v Lane NO* 1998 (1) SA 300 CC [53].

Determination of a violation requires a preliminary enquiry into whether the impugned provision differentiates between people or categories of people.[81] If there is no differentiation there is no violation, but if there is a differentiation then the two-stage analysis commences.[82] Point *(a)* above, concerns the right to equal treatment and equality before the law in section 9(1).[83] It tests whether there is a rational connection between the differentiation in question and a legitimate governmental purpose that is designed to further or achieve. If this question is answered in the negative, then the impugned law or conduct violates section 9(1) and it fails at the first stage.[84] If the differentiation is found to be rational then point *(b)* above comes into action.[85]

Basically, both unfair discrimination and differentiation without a rational basis can be justified as limitations of the right to equality in accordance with section 36. The *Harksen-formula* is systematic as the court first considers whether there was a violation of the right to equality before the law and then considers whether there is unfair discrimination.[86] If section 9(1) is violated the test stops there as it may be unnecessary to proceed further and determine whether a non-discrimination right has been violated.[87]

To summarise, there are three ways in which a law or conduct might differentiate between people or categories of people:[88]

i. First, 'mere differentiation' which might treat some persons differently to others, does not amount to discrimination.[89] It

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80 Currie 216.
81 *Ibid.*
82 *Ibid.*
83 *Ibid.*
84 *Ibid.*
85 *Ibid.*
86 *Ibid.*
87 *Ibid.*
88 *Idem* 217.
89 *Prinsloo v Van Der Linde* 1997 (3) SA 1012 (CC) [25].

will fail section 9(1) unless it has a rational connection to a legitimate government purpose;

ii. Secondly, differentiation which amounts to unfair discrimination which is prohibited by sections 9(3) and (4). Even if there is a rational connection, the differentiation will still violate the equality clause if it amounts to unfair discrimination;

iii. Thirdly, differentiation which constitutes 'fair discrimination', which is law or conduct that discriminates but does not do so unfairly, taking into account the impact of the discrimination on the complainant and others in their situation.

These extensive provisions and qualifications have bearing on the Basson case in that, as does every other citizen, he enjoys the protections and liberties offered by the Constitution subject to the limitations contemplated in section 36.

5.4.2 Section 10 – Human dignity:

Dignity must be respected and protected as it is a value that informs the interpretation of possibly all other fundamental rights and it is pivotal to the limitations enquiry.[90] The allegations levelled against Basson are of a serious nature, but it seems possible to construe that the manner in which they have been reported on impairs his dignity. [91] Reports in the media demonstrate bias in their selective representation of evidence in support of the prosecution. Seldom have they reported on the mistakes made by the Disciplinary Committee, such as the evidence of Professor Benetar that contradicted their contention. In respect of his professional career there has been damage. After the disciplinary hearing Basson's accreditation as

90 Currie 253. See also *Dawood v Minister of Home Affairs* 2000 (3) SA 936 (CC) 17.

91 It appears as if the criminal charges (or some of the evidence offered) on which Basson was acquitted form the basis of the disciplinary hearing. Some elements of the media have convicted and sentenced Basson in the court of public opinion, which does not support a notion of objective reporting.

a clinical supervisor at the Durbanville Mediclinic, which assists in training medical students for the University of Stellenbosch, was revoked.[92]

Should his guilty conviction be set aside in light of the judgment in *Basson v Hugo*[93], there are reasonable grounds for Basson to institute a damages claim against the HPCSA in terms of the common law *actio iniuriarum* for the damage that his reputation suffered.[94] The test for such a claim lies in that the claimant must prove that the conduct complained of subjectively and objectively was insulting and as a result he suffered damages.[95]

5.4.3 Section 16 – Freedom of expression:

This section affords individuals the right to do research, publish the results and to distribute the results through teaching without government interference.[96] Certain forms of expression fall outside the scope of the right, such as propaganda for war, incitement to violence and hate speech.[97] In principle, the closer the expressions come to action and the further it drifts from ideology and opinion, the less protection it will receive.[98]

The right to academic freedom vests in the individual academic and not in the university as this ensures that government cannot regulate universities to prohibit research that is critical of government policies and render academic freedom null[99] In turn, a certain amount of institutional autonomy is granted to institutes of higher learning and encumbers the government with a duty to ensure that there are adequate and functional

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92 https://www.iol.co.za/news/south-africa/western-cape/students-refuse-to-be-taught-by-basson-1946246. See also http://www0.sun.ac.za/tsr/wp-content/uploads/2016/02/WouterBasson.pdf (accessed on 17 December 2018).

93 *Basson v Hugo & Others* (2018) All SA 621 (SCA).

94 *Delange v Costa* 1989 (2) SA 857 (A).

95 *Ibid.*

96 Currie 352.

97 *Islamic Unity Convention v Independent Broadcasting Authority* 2002 (4) SA 294 (CC) [32].

98 Currie 342.

99 *Idem* 352.

academic institutions. Alternatively, there is a demand on the state to provide the financial backing to ensure that the right to academic freedom and research may be properly exercised.[100]

It is possible to argue, subject to the required approval from the relevant statutory bodies, theoretically Basson is free to conduct research into biological and chemical weapons and to publish his findings and even to lecture. But, the HPCSA and government are wary given his history and the chances of Basson obtaining permissions are limited. In any case as contemplated in section 16(2) research that propagates war, incites violence or advocates hatred Is not permitted. This is not the same situation as the refusal to grant permission to conduct scientific research into fields such as biotechnology (stem cells) which raises concerns of the infringement of the freedom of scientific research without proper cause or reason.[101]

5.4.4 Section 22 – Freedom of trade, occupation and profession:

The regulation of occupations does not deny persons the right to choose their occupation or profession.[102] The right to choose an occupation can be limited only by a law of general application that complies with the criteria set out in section 36.[103]Measures that attempt to close down a certain profession is not a regulation, however measures that restrict access to a profession may be regulation, such as the requirement to hold a certain qualification in order to practice in certain professions such as law or medicine.[104] Occupational freedom is an individual right to provide materially for oneself and to live profitably, in a dignified and fulfilled manner.[105]

However, it is a restricted right as no person has an absolute right to occupy himself with something that is clearly a crime or is an unlawful

100 *Ibid.*
101 *Ibid*.
102 *Idem* 467.
103 *Ibid.*
104 *Idem* 468.
105 *Idem* 465. See also *Affordable Medicines Trust v Minister of Health* 2006 (3) SA 247 (CC) [59].

income-producing activity.[106] Interference with occupational freedom may take several forms, however the freedom to be occupationally active involves more than the freedom of occupation.[107] Several occupations are regulated by certain provisions, such as the advocates' profession which until recently relied on the referral rule to provide work. Advocates were prohibited from taking instruction directly from clients and had to rely on attorneys sending them briefs.

This rule can be regarded as an infringement of the right to practice a profession, for example in the case of *De Freitas*[108] the court found that if an advocate takes instruction directly from clients and is found guilty of unprofessional conduct, suspension is an appropriate sanction. This case emphasises the need for rationality in regulation in order to avoid arbitrary actions and the impediment of the profession. In choosing a certain profession, one is bound by the regulations and the laws governing the profession, such as the Attorneys Act 53 of 1979, but the regulation is subject to constitutional control.[109]

In this regard Basson is allowed to practice his profession, despite the guilty verdict delivered by the disciplinary committee. However, once a sanction has been imposed he may be subject to certain regulations which prohibit him from practising for a specified period or at all. It is probable in the event permanent deregistration as a practitioner is imposed, the matter will be taken to court. Basson is likely to ask for the court to set aside the sanction and to request interim relief to allow him to practice pending determination of the main application.[110] This probability delays settlement of the matter.

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106 *Idem.* See also *JR 1013 Investments CC v Minister of Safety and Security* 1997 (7) BCLR 925 (E) [929].

107 *Idem* 466.

108 *Society of Advocates of Natal v De Freitas* 1997 (4) SA 1134 (N).

109 Currie 467.

110 Basson might have a good case to make out in this regard if one considers the implications of *Janse van Rensburg NO v Minister van Handel en Nywerheid* 1999 (2) BCLR 204 (T) on the prevention of the continuation of business activities before the investigations are completed.

5.4.5 Section 27 – Health care, food, water and social security:

Considering the state of health care in the country and the duty imposed on the government to provide adequate health care within its available resources, it could be argued that South Africa needs as many competent medical practitioners as it can get.[111] The financial resources are strained and the government struggles to fulfil its socio-economic mandate.

This situation is confirmed by the evidence in the matter of *Soobramoney*[112] where the appellant complained that his right to health care was infringed by the Department of Health by their failure and/or refusal to provide dialysis treatment as he was not a candidate for a kidney transplant. The court held that the state is required to take reasonable legislative and other measures within its available resources to achieve the realisation of rights.[113] The limited availability of resources meant the appellant's rights were not infringed and the appeal failed.[114]

By limiting the supply of dialysis treatment to certain patients other services can be provided. The government is not given a free hand in deciding on how it fulfils its duties and a lack of resources does not provide a waiver with regard to offering primary care.[115] In light of the interrelated nature of the various rights contained in the Bill of Rights this right implicates many of the health problems that the state health care facilities face which are the result of other socio-economic issues such as a lack of good nutrition, clean water and sanitation.[116]

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111 Bateman, C "Doctor shortages: unpacking the 'Cuban solution'" *South African medical journal* 103.9 (2013) 603 – 605. See also https://www.medicalbrief.co.za/archives/motsoaledi-crippling-sas-ability-train-enough-doctors and https://ewn.co.za/2014/05/13/Doctor-shortages-not-unique-to-SA (accessed on 17 December 2018).

112 *Soobramoney v Minister of Health (Kwa-Zulu Natal)* 1998 (1) SA 765 (CC).

113 *Ibid.*

114 *Idem* [59]. The judgment provides that the rights of the appellant would be infringed if government refused/failed to provide emergency health care.

115 Currie 582.

116 Law of South Africa 13(3) 234.

It is difficult to justify an action that leads to the removal of a competent doctor from the already overburdened health care system. Basson is a highly qualified cardiologist and there is a great shortage in the supply of medical specialists. An increase in the burden on the health care system infringes the right to health care, in this case the state is the author of its own detriment. The courts are reluctant to interfere; they respect the discretion of the government in the application of its resources as a democratic practice.[117]

In essence, the court will intervene if government takes no steps to realise a right by compelling them to take action. Alternatively, if implemented measures are not reasonable the court may review them and set them aside as its constitutional duty.[118] Emergency treatment, for example, cannot be refused; however, this right is qualified by stating that the hospital must be *able* to provide the necessary treatment.[119] Further, this right is limited as the Constitution does not require optimal health care, but merely adequate treatment.[120]

When he was found guilty by the HPCSA disciplinary committee Basson no longer was allowed to mentor students. It is submitted it is absurd to deprive students and patients of his skills. As no sanction has been imposed he ought to be allowed to teach and to assist in the care of patients. In light of the outcome of the review proceedings in the Pretoria High Court and the SCA judgement,[121] there is a reasonable probability that the disciplinary conviction may be set aside purely on the basis of the bias of two members of the Disciplinary Committee. If the conviction is set aside, Basson could resume mentoring students, which in my opinion is a situation which greatly benefits the state.

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117 Currie 583.

118 *Idem* 584. See also *Mazibuko v City of Johannesburg* 2010 (4) SA 1 (CC) [67].

119 S 27(3).

120 *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C) [49].

121 *Basson v Hugo & Others* (2018) All SA 621 (SCA).

5.4.6 Section 33 – Just administrative action:

In terms of section 33(2) anyone whose rights have been affected adversely by an administrative action has the right to insist on being given reasons in writing.[122] National legislation must be enacted to give effect to these rights and must provide for the review of administrative action by a court or, where appropriate, an independent and impartial tribunal.[123] Administrative action is conduct of an administrative nature performed by public authorities or private persons and entities when they exercise their public powers or perform public functions.[124]

This section is designed to protect the rights of citizens by prohibiting legislative interference and unlawful administrative actions in conjunction with the enactment of the Promotion of Administrative Justice Act 3 of 2000 (PAJA).[125] PAJA effectively gives effect to section 33. Currently, there is no common law means by which one may challenge an exercise of public power as the common law remedies have been absorbed into the Constitution and are exercised through PAJA.[126] However, common law remedies may be exercised, albeit in a narrow sense, against private entities not exercising statutory or public powers, when such entities are required to observe the principles of administrative law.[127] As alluded to administrative action is the exercise of public power by an organ of state except the legislature when exercising legislative functions, the judiciary when exercising judicial functions, the president when exercising the constitutional powers of the head of state and the national and provincial cabinets when making political decisions.[128]

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122 S 33(2).
123 S 33(3)(a).
124 Currie 647.
125 Currie 645.
126 *Idem* 647.
127 *Idem* 648.
128 *Idem* 653 – 654.

To summarise, an action is regarded as an administrative action under PAJA if it is a decision by an organ of state or a natural/juristic person when exercising a public power of performing a public function, in terms of any legislation or in terms of an empowering provision that adversely affects rights, having direct external legal effect and is not excluded specifically by the exclusions in the definition.[129]

Basson exercised the rights covered by these provisions in the matter of *Basson v Hugo*[130] The appeal centred on the provisions in section 7(2) of PAJA which require a complainant first to exercise internal remedies offered before approaching the court for relief.[131]Basson argued that in this matter the court ought to exercise discretion and find exceptional circumstances to exempt him from exhausting his internal remedies first as the sanctions imposed by the disciplinary committee remain in force until an appeal to the *ad hoc* appeal committee has been finalised.[132] This is the main ground for the application for review.

The court held that impartiality is a fundamental principle in the constitution and courts/tribunals not only are required to be impartial but also must be seen to be impartial.[133] Furthermore, in the event that the members of the disciplinary committee would be required to recuse themselves, the proceedings before them would be rendered a nullity and consequently any appeal in terms thereof either would be a nullity or not appealable at all.[134]Consequently, the appeal was upheld with costs and the matter remanded to the court *a quo* for determination of the review application,[135] which was successful.

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129 S 1 of PAJA. See also Currie 656.

130 *Basson v Hugo & Others* (2018) All SA 621 (SCA).

131 *Idem* [8].

132 *Idem* [9].

133 *Idem* [26].

134 *Idem* [27].

135 *Idem* [29].

5.4.7 Section 34 – Access to courts:

This section guarantees three rights to a person involved in a dispute that can be resolved by law. First, it creates a right of access to a court, tribunal or forum;[136] second, it requires tribunals and forums to be impartial[137] and third, it guarantees that disputes are decided in a fair and public hearing.[138] In order to access this right, the threshold that must be met is that the dispute must be resolvable by law.[139]

The purpose in guaranteeing access to a court is to provide protection against actions by the state or others that would deny them that right. [140] In Basson's case his legal team realised that this right provided an opportunity for them to approach the court to resolve the recusal issue in respect of the disciplinary hearing. His case is a dispute that is resolvable in court and therefore he is entitled to approach the court for appropriate relief.

The court confirmed the importance of the guarantee of impartiality in the actions of tribunals/courts and if it not for this Basson would have had little recourse against the HPCSA. The importance of guaranteeing access to courts in order to resolve disputes is emphasised by this matter[141]Basson enforced the only remedy available to an aggrieved practitioner who wishes to proceed with his medical practice while awaiting sanction, which is to apply for an interdict prohibiting the hearing from proceeding pending the finalisation of the review matter. This strategy may have been suggested by the matter of *De Beer v Raad vir Gesondheidsberoepe van Suid-Afrika[142],* in which the applicant requested

136 Currie 711.

137 *Ibid.*

138 *Ibid.* See also *Lufuno Mphaphuli & Associates (Pty) Ltd v Andrews* 2009 (4) SA 529 (CC).

139 *Ibid.* See also *De Beers Consolidated Mines (Pty) Ltd v CCMA & Others* (2010) JOL 25672 (LC) [18].

140 *Idem* 714.

141 *Basson v Hugo & Others* (2018) All SA 621 (SCA).

142 *De Beer v Raad vir Gesondheidsberoepe van Suid-Afrika* 2004 (3) BCLR 284 (T).

an interdict prohibiting his removal from the register pending finalisation of the appeal process.

The review application was successful, it is doubtful it ends the matter. The HPCSA might appeal the main application and it is possible there is a further appeal to the Constitutional Court. Both parties rely on a right to approach the courts.

5.4.8 Section 35 – Arrested, detained and accused persons:

In terms of section 35(3) an accused person has a right to a fair trial, which right includes the right to have a trial commence and conclude without undue delay,[143] to be presumed innocent,[144] not to be compelled to give self-incriminating evidence,[145] not to be convicted for an act or omission that was not an offence under either national or international law at the time it was committed or omitted,[146] not to be tried for an offence in respect of an act or omission for which that person has previously been either acquitted or convicted,[147] and to appeal to or ask for a review by a higher court.[148]

The provision of a right to a speedy trial is aimed at protecting the accused person's liberty, personal security and related interest.[149] Basson's criminal trial commenced in 1999 and judgment was delivered in 2002. Two appeals followed of which the last was heard in 2005. If Basson were to be recharged on the quashed charges, he would have been on trial for more than 6 years and it follows that if a new prosecution commences, the delay in prosecution could be raised by the defence in an application for a permanent stay of prosecution.

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143 S 35(3)(d).
144 S 35(3)(h).
145 S 35(3)(j).
146 S 35(3)(l).
147 S 35(3)(m).
148 S 35(3)(o).
149 Currie 798.

In *S v Steward*[150] an unreasonable delay was declared to be unacceptable and to be avoided by the trial courts. Those culpable in the delay (whether the prosecution or the defence) must account to their respective professional bodies. More recently this constitutional aspect in law has been raised by the defence for former President Zuma in his criminal case dating back to 2007.[151]

Section 342A of the Criminal Procedure Act 51 of 1977 (CPA) compels the court to investigate undue delays in completion of the prosecution, which could cause substantial prejudice to the prosecution, the accused or his defence team, the state, or witnesses.[152] Section 342A(2) of the CPA dictates that in determining whether the delay is unreasonable, the court must take into account the following factors:

- The duration and reasons for the delay;
- Whether anyone can be blamed for the delay;
- The effect of the delay on the personal circumstances of the accused, witnesses and the effect on the administration of justice;

The potential prejudice to the state or defence must be taken into account and the court must take into consideration:

- The weakening of the quality of evidence;
- Death or disappearance of witnesses;
- Loss of evidence;
- Difficulties in gathering evidence and costs.

150 *S v Steward* 2017 (1) SACR 156 (NCK).

151 https://www.news24.com/SouthAfrica/News/zuma-expected-to-file-papers-seeking-a-permanent-stay-of-prosecution-20181116 (accessed on 17 December 2018).

152 S 342A(1) of the Criminal Procedure Act 51 of 1977.

The court is compelled to take into account the adverse effects of the delay on the interest of the public or victims if the prosecution is stopped as well as the nature of the case.[153]

In determining whether the delay is unreasonable, the court must consider all the above factors holistically and balance the respective interests of the affected parties.[154] In accordance with section 342A(3) of the CPA the following open list of remedies is available in the event that the court determines that the delays in the matter are unreasonable:

- Refusing further postponement;
- Granting a postponement subject to conditions;
- Before plea, the matter may be struck from the roll and may not be reinstituted without the written instruction from the NDPP;
- After plea, order that the matter proceed as if the delaying party's case has been closed;
- Granting a cost order against the delaying party.

A permanent stay of prosecution may be considered only if exceptional circumstances are present and are orders of a last resort.[155] In the matter of Basson it is submitted a second prosecution would be ill advised considering the already lengthy delay and the reasonable prospect of success in an application for a permanent stay of prosecution by Basson.

In regard to the presumption of innocence the court has acquitted Basson on several charges. Consequently, this right is not infringed even if he has been convicted in the court of public opinion. On the other hand at the disciplinary hearing Basson has been asked to give evidence in

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153 *Ibid.*

154 Currie 798.

155 *Idem* 799. See also *McCarthy v Additional Magistrate, Johannesburg* 2000 (2) SACR 542 (SCA). S 342A(4).

respect of facts already presented at the criminal trial raising the issue of self-incrimination.

An accused person's right not to be convicted of an offence that was not an offence under national of international law at the time that it was committed is known as the principle of legality.[156] In other words, there is no basis for a conviction if the there is no legality with respect to the alleged offence.[157] This principle restricts a courts' extension of the common law definition of a crime, even in circumstances where the purpose is to promote constitutional values.[158] Basson was acquitted of offences committed outside the borders of South Africa as it was determined this court did not have jurisdiction to entertain the matter and therefore a conviction could not be attained. This determination was overturned in the Constitutional Court as the parties conspired to commit the offences in Pretoria which situation confirmed the legality of the possible conviction.

It has been questioned that the prosecution failed to include international instruments in the original indictment as the manufacturing of chemical and biological weapons is prohibited. It is an offence in terms of international law and consequently could have been exercised by the prosecution.

A person's right not to be tried for offences of which he was previously acquitted is known as the *autrefois acquit* principle.[159] In this regard Basson is on firm ground in opposing further prosecution. Initially, Basson had been acquitted on several charges which the NPA (partially) successfully appealed to the Constitutional Court. The Court set aside the quashing of some of the charges on which Basson had been acquitted relating to the committal of offences outside of the borders of South Africa

156 Currie 801.

157 *Ex parte Minister of Safety & Security: In re S v Walters* 2002 (4) SA 613 (CC).

158 Currie 801. See also *S v Mshumpa* 2008 (1) SACR 126 (E) [55].

159 Also found in s 106(1) of the CPA.

in accordance with the Riotous Assemblies Act 17 of 1956. However, the NPA declined to prosecute him on the charges as the evidence needed to convict inextricably is linked to evidence and charges on which Basson was acquitted. The decision not to prosecute in all probability is based on the knowledge that Basson has a reasonable prospect of success with an application for a permanent stay of prosecution due to the delay as well as fear of triggering the double jeopardy-rule which prohibits a second prosecution on the same charges and on similar evidence.

The HPCSA it seems attempted to prosecute Basson *de novo* on much of the same evidence. From the HPCSA charge sheet it appears as if the disciplinary hearing based its case on the evidence in the criminal trial. For example, a charge is for the alleged production of mortar shells containing chemical substances in the explosives identical to the charge in the criminal trial. It is common cause that some of his actions contravened international conventions. However, a prosecution based on facts available at the time of his acquittal opens the door for him to argue that he is being prosecuted by the HPCSA on similar charges which are inter-related.

Considering the bias-defence Basson successfully raised in the SCA[160] and High Court[161] an attempt at renewed prosecution might result in the matter commencing afresh before a new committee producing further delay and further reviews and/or appeals. It is apposite to reiterate that whatever the decision of the disciplinary committee there will be subsequent appeals or review applications to follow.

5.4.9 Section 39 – Interpretation of the Bill of Rights:

According to section 39(1) when a court, tribunal or forum interprets the Bill of Rights it must promote the values that underlie an open and

160 *Basson v Hugo* (2018) All SA 621 (SCA).

161 *Dr Wouter Basson v Professor JFM Hugo & 2 others* (GP).

democratic society based on human dignity, equality and freedom,[162] and must consider international law,[163] and may consider foreign law.[164] When a court, tribunal or forum interprets any legislation and when developing the common law or customary law it must promote the spirit, purport and objects of the Bill of Rights.[165] The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill of Rights.[166]

During the appeal in the Constitutional Court appeal[167] the issue of international law was raised and begs the question why the prosecution had not included any reference in the initial indictment. The Court pointed out that Basson was in contravention of several conventions and of international human rights law and international humanitarian law.[168]

As stated in *S v Makwanyane*[169] the international agreements and customary international law provide a framework within which the Bill of Rights may be interpreted and as such decisions of international tribunals may provide guidance in regard to the correct interpretation of certain provisions. This interpretation is not confined to instruments that are binding on South Africa.[170] The obligation to take international law into account is a means by which the Constitution creates unity between South Africa's external obligations under international law and their internal domestic impact.[171] Furthermore, section 231(4) of the Constitution

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162 S 39(1)(a).[163] S 39(1)(b).[164] S 39(1)(c).[165] S 39(2).

163 S 39(1)(b).[164] S 39(1)(c).[165] S 39(2).

164 S 39(1)(c).[165] S 39(2).

165 S 39(2).

166 S 39(3).

167 S *v Basson* 2005 (12) BCLR 1192 (CC) [170 – 174].

168 *Idem* [177] – [179]. Specific reference made to Common Article 3 of the Geneva Conventions.

169 *S v Makwanyane* 1995 (3) SA 391 (CC) [36] – [37].

170 Currie 147.

171 *Glenister v President of the Republic of South Africa* 2011 (3) SA 347 (CC).

provides for the domestication of international law through national legislation and also provides that customary international law forms part of domestic law in as far as it is consistent with the Constitution and domestic legislation.[172] These features in turn allow the courts to develop the common law.[173]

Section 39(2) stresses the importance for all courts when interpreting and applying legislation to have regard to the spirit and objects of the Bill of Rights[174] It is submitted that had the international legal instruments been included in the indictment Basson would have had a more arduous task in gaining an acquittal. An examination of international law greatly would have contributed to the development of South African law and in particular common law offences and the common law in general. International law does not prescribe specific sentences for certain offences, but grants that privilege to the domestic courts.[175] The *nulla poena sine lege* principle applies in the same manner in international law as it does in our domestic common law.[176] Even if the outcome had been an acquittal reference to international law gives the courts greater freedom and the courage to enter the realm of international instruments that are available to be utilised by our courts and would make them seem less exotic.

5.5 Conclusion

The statutory and constitutional positions set out above show clearly in which legal framework medical practitioners function and from what the HPCSA derives disciplinary powers. The chapter examines the means by which Basson enjoys the protection of the Constitution and to what extent his defence team might utilise constitutional principles in

172 Cheadle, M *et al South African Constitutional Law: The Bill of Rights* 33.1.
173 *Carmichele v Minister of Safety & Security* 2001 (4) SA 938 (CC).
174 *Du Plessis and Others v De Klerk and Another* 1996 (5) BCLR 658 (CC).
175 Heads of Argument, *S v Basson* 2005 (12) BCLR 1192 (CC) 110 – 111.
176 *Ibid.*

the disciplinary hearing. Basson successfully raised several technical defences[177] but has been found guilty on the merit of the charges. At the time of drafting this chapter the review application for the recusal of Professors Hugo and Mhlanga was successful but the further outcome of the disciplinary hearing and the sanction are awaited.[178]

177 *Basson v Hugo & Others* (2018) All SA 621 (SCA).

178 *Dr Wouter Basson v Professor JFM Hugo & 2 others (GP).*

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The thesis presents a discussion of the law and ethical guidelines applicable in making a judgment about Dr Basson's conduct and points the way to what conclusions may be drawn. I start by revisiting the research questions posed in chapter 1.

6.2 Conclusions as to the research questions

6.2.1 Are there international or South African medical ethical rules prohibiting medical professionals from conducting research into or assisting in the manufacture of biological or chemical weapons for military purposes? If so, what are these ethical rules and which sanctions may be imposed on a violation of these rules and/or laws?

The laws and rules that regulate the conduct of medical practitioners were discussed at length in chapters 3 – 5. The WMA has adopted several declarations prohibiting the manufacturing of chemical and biological weapons including the WMA Declaration on Chemical and Biological Weapons[1] and WMA Declaration of Geneva.[2] Further, international law rules in the case of the Biological Weapons Convention[3] and Chemical Weapons Convention[4] prohibit the production of these substances.

In South Africa the HPCSA extensively regulates the role of medical practitioners in research into biological and chemical weapons, for example the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act.[5] Rule 26 which

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1 WMA Declaration on Chemical and Biological Weapons (1990).

2 World Medical Association Declaration of Geneva (1948 and 2006).

3 Convention on the prohibition of the development, production and stockpiling of bacteriological and toxin weapons and on their destruction 26 March 1975, 1015 UNTS 163.

4 Convention on the prohibition of the development, production, stockpiling and use of chemical weapons and on their destruction 29 April 1997, 1974 UNTS 45.

5 Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act 56 of 1974 (as amended) as discussed above in ch 5.2 and 5.3.

relates to research into and the development of chemical and biological weapons clearly states that a practitioner involved in research or in the development or use of defensive chemical, biological or nuclear capabilities shall obtain prior written approval from the board concerned to conduct such research, development or use and shall provide a thorough exposition of the research to ensure that it is permissible.[6]

The HPCSA has produced a series of booklets directed at members, which deal with aspects of practice including research into and the development of chemical and biological weapons in Booklet 8.[7] It reiterates the stipulation that a health care professional involved in chemical and biological weapons research shall obtain permission from the HPCSA and furnish it with the full nature and scope of the research and its intended use and explain in which way the research complies with the various declarations and conventions to which South Africa is a signatory.[8]

Health care practitioners who transgress the international declarations and conventions may be sanctioned by the International Criminal Court (ICC) in cases where international criminal law has been transgressed. In a matter of this kind a prosecutor investigates the alleged misconduct and if satisfied there is a *prima facie* case, a warrant of arrest is issued. Upon the arrest of the accused person by a member state the accused is delivered to the ICC for trial. If convicted, a custodial sentence may be imposed. Organisations such as the World Health Organisation and World Medical Association also are in a position to apply pressure on state health organisations to impose sanctions on practitioners who transgress. The local situation is that the HPCSA convenes a board to inquire into the alleged misconduct and if the member is convicted, one of the following penalties may be imposed:

(a) either a caution, reprimand, or both; or

(b) suspension from practice for a certain period; or

(c) removal of the accused's name from the register; or

(d) a fine; or

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6 *Idem* 28.

7 HPCSA (2008) Guidelines for good practice in the health care professions (Booklet 8).

8 *Idem* 2 – 3.

(e) compulsory period of professional service determined by the professional board; or

(f) payment of costs of proceedings, restitution or both.[9]

In applicable cases the matter may be referred to the National Prosecuting Authority for further criminal investigation and prosecution, *inter alia* with regard to offences such as common assault, culpable homicide, attempted murder or murder. Transgression of the provisions of sections 53 – 68 of the National Health Act 61 of 2003 which deal with the control and use of human tissue also are prosecuted.

6.2.2 What potential ethical or legal justifications for research into biological/chemical weapons may be presented? Are medical professionals in a military situation present in the role of soldiers or medical practitioners or both?

An ethical or legal justification for research into biological and/or chemical weapons often offered is the promotion of an increase in bio-safety and bio-security. The purpose of the research into these weapons might have the aim of preventing the propagation of information which would lead to atrocities being committed by criminal organisations and to discover treatments against the effects of these weapons.[10] Countries such as the United States, the United Kingdom and the Netherlands are proactive in establishing research facilities which focus on the effects of chemical and/or biological weapons and the development of vaccines.[11]

Chapter 4 above examined the context which establishes whether the medical professionals involved in research into chemical and biological weapons act in their capacity as soldiers or as a practitioner.[12] It is argued that if they act under orders in a military capacity they should be regarded as doing so as soldiers. In respect of acting in

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9 S 42(1) of the Health Professions Act 56 of 1976.

10 Frinking, E 'The increasing threat of biological weapons: Handle with sufficient and proportionate care' The Hague Centre for Strategic Studies (2016) 22.

11 *Idem* 26 – 30.

12 Ch 4.6.

obedience to an unlawful command it is suggested the soldier can refuse to execute the order and should report the incident to the relevant superior authority.

If the research is conducted in the role of a medical practitioner, then even if a military doctor, the practitioner is viewed as a member of the profession and not in a military capacity. Sections 4.5 and 4.6 of the chapter above presented the argument in the case of Basson that he conducted the research in a military capacity and was not directly involved in the production or distribution of the substances in question. He was the commanding officer of 7 Medical Battalion, but his research did not involve patients, and evidence could not be adduced that he personally distributed, manufactured or administered the substances. It is submitted that this view can be defended and Basson acted in the scope and role of the commanding officer of a military unit ordered to conduct research.

The argument that the research depended on medical knowledge is dismissed as the knowledge is independent of Basson's personality or his function as commanding officer. It could not be established there was a doctor-patient relationship between Basson and the "targets". Nevertheless, directly or indirectly Basson relied on his medical knowledge in overseeing the research at Project Coast in the awareness that the work contravened certain conventions, which is sufficient to trigger a disciplinary prosecution. However, after his acquittal in the criminal trial and a lack of evidence with regard to his personal involvement the HPCSA disciplinary committee faces an arduous task in succeeding to impose an appropriate sanction.

6.2.3 Should medical professionals previously involved in alleged unethical conduct during military service at a later stage be allowed to practice medicine in the civilian health sector? What arguments can be presented for and against their involvement?

In order to respond to this question, the specifics of the particular case had to be considered. For instance a successful prosecution at a disciplinary hearing during military service for a serious breach of medical and/or professional ethics could imply a

serious risk if the person is admitted to return to the practice of medicine.[13] As stated in the WMA Declaration of Geneva[14] against all forms of influence medical professionals must maintain the utmost respect for human life.[15] Read together with the WMA Regulations in Times of Armed Conflict[16] it confirms that medical ethics in times of war are the same as in peace time and that the primary objective of medical professionals is to preserve life.[17] Consequently, and in accordance with the WMA Declaration of Tokyo,[18] medical professionals will not condone or participate in torture proceedings or provide the knowledge to facilitate such processes.[19] A medical professional who violates this principle faces the severest test for readmission. Those charged with committing lesser offences and/or those since their first disciplinary action not charged and/or convicted again may be dealt with less severely. It is argued that each case should be decided on its merits in order to obviate a procedure which is arbitrary and results in the exclusion of those whose services are needed.[20]

It is submitted that military doctors have a unique skill set as a consequence of their combat experience and work efficiently under pressure. They are able to improvise in an emergency and their abilities are an asset in emergency rooms and in trauma practices. They have an abundance of experience, the ability to work independently, decisively and confidently and are invaluable in the training of interns and junior personnel. The result is more efficient practice with a reduced risk of malpractice arising from a lack of experience.

There is a great need for medical professionals in general, and it would be irresponsible to exclude on arbitrary grounds those with experience. Necessarily, there is a risk in allowing military medical professionals back into private practice. Many

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13 https://edition.cnn.com/2019/06/20/us/eddie-gallagher-navy-seal-trial/index.html. In this matter, an operational medic has admitted to suffocating an injured enemy combatant.

14 World Medical Association Declaration of Geneva (1948).

15 See also ch 4.6.

16 World Medical Association Regulations in Times of Armed Conflict (1956 & 1983).

17 *Ibid.*

18 World Medical Association Declaration of Tokyo (1975).

19 *Ibid.* See also ch 4.6.

20 In this regard refer to the discussion of Basson v Hugo & Others (2018) 1 All SA 621 (SCA) in ch 4 and the subsequent principles of substantive enjoyment of rights and fair treatment of persons before the law confirmed by the court.

military veterans struggle with Post Traumatic Stress Disorder (PTSD) and military medical professionals fall into the same category. An inadequate adjustment to civilian life may result in discord between them and private practice colleagues; perhaps they are less familiar with the type of patient presenting in private practice. If the former military medical professional is unable to adapt their manner this could result in malpractice and the civilian practice needs to manage the risk. It may be advisable to provide a transitional training to military medical veterans entering private practice to ensure they comply with the statutory provisions as well as the method of practice in civilian health care.

6.3 Recommendations

In general it is proposed that military medical veterans are permitted to practice in private health-care dependent on a successful evaluation on a case-by-case basis. Basson's case is more complex because even if it is acknowledged that as the commander of a military unit appointed to research chemical and biological weapons he was foremost a soldier, he is also a medical professional who relied on his medical knowledge. He was successful in one role because he was highly-qualified in the other; he needed his medical knowledge to command his medical unit. Of course, had Basson refused to carry out his instructions, the likelihood is the objectives would be gained by other means. By fulfilling his mandate Basson infringed various WMA declarations as well as medical ethics.[21]

In the event that a similar situation should arise, those in command and their subordinates must be more cognisant of their duties and responsibilities in adhering to medical ethics and the law in general. In the eventuality that the SANDF continues with this type of project it is to be hoped the participants receive in-depth ethics instruction and there is ethical leadership at the helm. Greater oversight by government departments and non-governmental organisations is essential to ensure that arms of the state do not exceed their mandate creating a situation which is susceptible to abuse and

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21 Ch 4.5 and 4.6.

the misappropriation of resources. The ethics foundation of clandestine operations should be upheld as with all other projects involving medical professionals and work on biological and chemical weapons.

It is probable that the HPCSA seeks to suspend Basson from practice for a period or even rule in favour of his permanent removal from the register. It is submitted that the latter sanction is inappropriate as some of the charges brought against Basson could not be proven and in the criminal trial he was acquitted of all charges.[22] Basson is near the end of his career and a harsh penalty seems redundant. It is proposed that a more meaningful sanction would be suspension followed by a period of community service in order to make restitution to the community he served so ill.

Basson's record since he left the military has been exemplary - he is a specialist cardiologist and in internal medicine. These specialisations are greatly needed. The state of the public health services means society can ill afford the loss of his skills and his removal from the medical register is not in the public interest, thus community service is a more appropriate application of a sanction against someone whose actions so greatly damaged the health of the community. His abilities would be in the service of the public and in a measure would be recompense for the cost to society.

The prosecution in the case faces serious procedural difficulties, of which Basson will take advantage. It is to be anticipated the litigation marathon will continue contesting either the recusal judgement[23] or the conviction by the now recused members of the committee. The matter will drag on; either the hearing commences *de novo* before a new committee or the sentencing hearing proceeds. In these circumstance witnesses or evidence may no longer be available, or Basson may retire which renders the process null. At time of drafting the HPCSA has indicated they will apply for leave to appeal the recusal judgment, however the matter has not served before the court.[24]

If the conviction of Basson fails it raises doubt as to the value to the HPCSA to pursue the matter which has been prolonged for the better part of a decade at enormous cost. It is suggested that a settlement would be more fruitful; continuing to

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22 See ch 4.5.

23 *Basson v Hugo* 2019 JDR 0707 (GP).

24 https://www.news24.com/SouthAfrica/News/hpcsa-to-apply-for-leave-to-appeal-wouter-basson-recusal-judgment-20190430 (accessed on 2 June 2019).

prosecute Basson gives the appearance of persecution and entails the possibility of considerable damage whatever the public interest. Whatever steps follow next in this saga will be followed with considerable interest.

This study highlights the susceptibility of medical knowledge and individual ability to be misappropriated to devastating effect. The study reaffirms the importance of a profound understanding and respect for ethical considerations in resolving the dilemma of reconciling medical practices and the dictates of other disciplines. The greatest possible clarity is necessary in the consideration of ethical regulation and requires a profound knowledge of the rules of behaviour provided by the declarations and conventions to safeguard the integrity of medical practice and of medical practitioners to the benefit of humanity. There is a duty to protect society against the abuse which depends on the medical profession being held accountable in times of war and in peace.

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