

IN DEFENCE OF THE VULNERABLE

'Manto, AIDS drugs DO work after rape.' Headlines from the *Mail & Guardian* of 18 January this year reflect the frustration felt by both lay and professional people in trying to convince our government that there is impressive evidence for the benefit of antiretroviral (ARV) drugs. The government continues to object to the administration of these agents from state hospitals. Recently the lay press has reported two very disturbing accounts of medical travesties. The first report concerns Rob Ferreira Hospital superintendent, Dr Thys von Mollendorf, who was found guilty of gross insubordination by a government tribunal last week. His crime was to allow volunteer workers to facilitate the provision of free ARVs to rape survivors. These volunteers, working for the organisation 'GRIP' (the Greater Nelspruit Rape Intervention Project), provided counselling, clothes, toiletries and legal advice to the traumatised survivors. The Mpumalanga health MEC, Sibongile Manana, accused Dr Von Mollendorf of embarrassing government and told provincial legislature 'that any non-profit, non-government or volunteer organisations that continued to defy provincial policy would be frozen out of the public health sector'. Using 'catch 22' logic she states that the reason for deferring roll-out of the mother-to-child transmission (MTCT) prevention programmes is lack of resources, including counselling, yet she bans voluntary organisations such as GRIP that are stepping into the breach and supplying these services.

The second episode involves Kimberley Hospital in the Northern Cape, where the health MEC of that province castigated the hospital staff and suspended one doctor for administering ARVs as HIV post-exposure prophylaxis to 'Tshepang', the 9-month-old baby who was sodomised and raped last November. These reports highlight the failure of state health services to provide life-saving interventions to vulnerable populations, and the



more sinister implication is the undermining of ethical and professional autonomy of doctors working in the state sector.

The value of ARVs to prevent MTCT has been demonstrated unequivocally in randomised controlled trials. In rape, where such trials in this vulnerable group are not ethically possible, the risks of HIV transmission are even higher.

In Africa the risk of HIV transmission due to rape is significant. The World Health Organisation has reported that two-thirds of HIV-positive women in Rwanda have become infected as a result of rape. In South Africa, where more than 1.6 million rapes occur annually, it has been estimated that the resulting risk of HIV infection may be as high as 40% because of high HIV prevalence rates and the frequency of gang rape. A local study reported by Dr Adrienne Wulfsohn at the 2001 IDSA conference in Stellenbosch described the 2-year follow-up of 1 000 rape survivors. Wulfsohn reported that no rape survivor

who received ARVs within 72 hours of the rape had become HIV-positive, and that prophylaxis was well tolerated. The findings of this important South African study have influenced the forthcoming Centers for Disease Control guidelines on HIV prophylaxis after rape and cannot be ignored by health care providers; they should be incorporated into health care policy as a matter of extreme urgency by our state health department. It is understandable and correct that the doctor facing a woman who has survived the devastation of rape will do whatever it takes to administer ARV prophylaxis to prevent the added death sentence of HIV infection. Not to do so would be to fail one of the most vulnerable sectors of our society. When these responsibilities are not met, the health profession must step in to advocate for these sectors. Those of our colleagues who do so and in so doing jeopardise their positions and face punishment by the state must be supported and championed by the rest of the profession.

The World Medical Association Declaration on Physician Independence and Professional Freedom of October 1986 states that 'Physicians must have the professional freedom to care for their patients without interference. The exercise of the physician's professional judgement and discretion in making clinical and ethical decisions in the care and treatment of patients must be preserved and protected'. The South African Medical Association Human Rights, Law and Ethics Committee adopted the following resolutions in July 2001: 'The committee affirms its strong support for the rights of medical practitioners to clinical independence and autonomy. This includes the right to treat patients without undue influence, pressure or victimisation from employers or government institutions. Medical practitioners are under an ethical duty to act in the best interest of their patients, who form an exceptionally vulnerable group in South African society. The committee also supports the rights of patients to receive necessary treatment, always with their informed consent'. This was further endorsed by a recent statement put out by the Colleges of Medicine of South Africa on

the controversy about the preventive treatment of HIV infection, which stated among other things that the Colleges believe it unethical and against medical principles to penalise doctors in the public sector who obtain and administer nevirapine to their patients (for mother-to-child transmission prevention) in the proper manner.

Indeed we are in serious trouble when South African doctors can no longer exercise professional judgement in providing the best perceived care for their patients without government or other interference. The legacies of the past should have taught us this lesson. When political ideology, political party lines or other governmental influences override the ethical and professional obligations of medical practitioners, indefensible acts are committed or basic medical care omitted by this same profession, and the memory of Dr Steve Biko will bear testimony to that.

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