Posttraumatic stress disorder criteria did not fit the clinical picture of our patient. Depersonalisation and dissociative identity disorder were also excluded.

We evaluated Mrs X monthly for 6 months and thereafter 6-monthly for one and a half years. Her clinical picture did not change over this period. Her recollection of the fugue is now partial, she is still functioning well at work and has been back home with her children.

We finally confirmed a diagnosis of dissociative fugue. The possible precipitating stressor in this case could have been the birth of the child, as well as repeated hospitalisations for caesarean section complications.

1. Gove PB, ed. *Webster's Third New International Dictionary of the English Language.* Springfield, Mass.: G & C Merlam, 1967: 918.
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 1st ed. Washington, DC: APA, 1952.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 2nd ed. Washington, DC: APA, 1968.
4. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 3rd ed. Washington, DC: APA, 1980.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 3rd ed, revised. Washington, DC: APA, 1987.
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington, DC: APA, 1994.
7. World Health Organisation. *International Classification of Diseases.* 10th ed. Geneva: WHO, 1992.
8. Slater M, Roth M, Mayer-Gross W, Slater E, Roth M. *Clinical Psychiatry.* 3rd ed. Baltimore: Williams and Wilkins, 1974.
9. Kaplan HL, Sadock BJ. *Synopsis of Psychiatry.* 8th ed. Baltimore: Williams and Wilkins, 1998.
10. Butler LD, Duran RE, Jasiukaitis P, Koopman C, Spiegel D. Hypnotizability and traumatic experience: A diathesis-stress model of dissociative symptomatology. *Am J Psychiatry* 1996; **153:** 42-63.
11. Riether A, Stoudemire A. Psychogenic fugue states: A review. *South Med J* 1988; **81:** 568-570.
12. Nemiah JC. Dissociative disorders. *Comprehensive Textbook of Psychiatry.* 6th ed. Baltimore: Williams and Wilkins, 1995.
13. Loewenstein RJ. Psychogenic amnesia and psychogenic fugue: A comprehensive review. In: Tasman A, ed. *Review of Psychiatry.* Vol. 10. Washington, DC: American Psychiatric Press, 1991: 189-222.
14. Lishman WA. *Organic Psychiatry.* 2nd ed. Cambridge, Mass.: Blackwell Scientific, 1987.
15. Coffey CE, Weiner RD. Electro convulsive therapy: An update. *Hospital and Community Psychiatry* 1990; **41:** 515-520.
16. Daniel WF, Grovitz HF. Acute memory impairment following electroconvulsive therapy. *Acta Psychiatr Scand* 1983; **67:** 1-7.
17. Good MI. Substance-induced dissociative disorders and psychiatric nosology. *J Clin Psychopharmacol* 1989; **9:** 88-93.
18. Akhtar S, Brenner I. Differential diagnosis of fugue-like states. *J Clin Psychiatry* 1979; **40:** 381-385.
19. McDonald JM. *Psychiatry and the Criminal.* 3rd ed. Springfield, Ill.: Charles C, Thomas, 1976.
20. Neki JS. Psychiatry in South-East Asia. *Br J Psychiatry* 1973; **123:** 257-269.
21. Meth JM. Exotic psychiatric syndromes. In: Arieti S, Brady EB. *American Handbook of Psychiatry.* 2nd ed. Vol. 111. New York: Basic Books, 1974.

AIDS FOCUS

Rape survivors and the right to emergency medical treatment to prevent HIV infection

David McQuoid-Mason, Ames Dhai, Jack Moodley

The South African Constitution provides that 'No one may be refused emergency medical treatment'.[1] The question arises whether rape survivors qualify for emergency medical treatment in terms of the Constitution, and if so who is responsible for providing such treatment. The decision by the South African Cabinet to implement antiretroviral treatment for rape survivors[2] seems to indicate that the government recognises that this duty lies with the state.

We therefore examine the meaning of emergency medical treatment; the duties of police officers, medical practitioners, state health institutions and private health institutions; and the role of non-governmental organisations with regard to rape survivors.

Professor David McQuoid-Mason is Professor of Procedural and Clinical Law at the University of Natal, and publishes and teaches in Medical Law. Dr Ames Dhai is an obstetrician and gynaecologist who holds an LLM degree in Medical Law and Ethics and is currently studying for a PhD in Medical Law at the University of Natal. Professor Jack Moodley is Chief Specialist and Head of the Department of Obstetrics and Gynaecology, University of Natal, and Director of the MRC Pregnancy Hypertension Unit.

Meaning of 'emergency medical treatment'

In the case of *Soobramoney v. Department of Health, KwaZulu Natal*[3] the Constitutional Court held that 'emergency medical treatment' means treatment arising from a 'sudden catastrophe which called for immediate medical treatment'. The Court held that in such instances a patient should not be refused ambulance or other available emergency services and should not be turned away from a hospital able to provide the necessary treatment. Remedial treatment that is necessary and available must be given immediately to avert harm.[3]

Rape, which is legally defined as 'intentional and unlawful sexual intercourse with a woman by a man without her consent',[4] constitutes a 'sudden catastrophe' which in the light of the incidence of HIV/AIDS in South Africa calls for immediate medical treatment to prevent the survivor from contracting HIV. The sooner prophylactic treatment is commenced and evidence collected the better are the chances of protecting the health of the patient and identifying the perpetrator. Rape is usually sudden, unexpected and may have catastrophic consequences for the survivor. The essence of the crime is the lack of consent by the rape survivor, which makes it unexpected. The consequences may be severe both physically and psychologically and, when considering the high risk of HIV infection, may be catastrophic since the survivor may be confronted with the possibility of contracting a fatal illness.

Given the high probability of HIV infection in South Africa, there is little doubt that a rape survivor qualifies for the constitutional right to emergency medical treatment as defined by the Constitutional Court.[3]

Duties of police officers

When making medical treatment accessible to people in their custody or care, the duties of the police are clear. Failure to provide medical treatment to such people may result in a damages claim against the state.[5] The police are required to provide access to medical treatment for victims and survivors of criminal conduct and criminals themselves who present, or who are in custody, at police stations.[6] The police may not send away a rape survivor who approaches them for help or keep her waiting for so long that it places her at risk of not being able to be protected by prophylactic treatment against HIV infection. The consequences of rape constitute a medical emergency, in the same category as the consequences of serious assault or motor collision, therefore the police should ensure that rape survivors receive immediate medical attention.[7]

If the police delay unnecessarily in providing a rape survivor with access to appropriate medical treatment (e.g. keep her waiting, for instance beyond 72 hours after the rape occurred, without taking her or arranging for her to be taken to a health care facility or practitioner), she may be unable to undertake effective prophylactic precautions to prevent contraction of HIV. She will then be able to sue them for damages for pain and suffering, loss of life expectancy, loss of income, and any medical expenses incurred as a result of such infection.

Duties of medical practitioners

There is no general ethical or legal duty on doctors to treat a stranger as a patient except in emergencies and such failure to treat is not unreasonable.[7] Such refusal must also not be contrary to the Constitution, for instance based on unfair discrimination[8] or in circumstances where the person is entitled to emergency medical treatment.[1] In addition there may be a contractual duty on a doctor, such as a district medical officer or a casualty officer at a hospital, to attend to patients who are brought in for treatment.[9] Sometimes such doctors may be faced with issues of dual loyalty in hospitals where the hospital authorities have not yet provided antiretroviral drugs for rape survivors.

Dual loyalty may arise where doctors are prevented by hospital authorities from providing certain prophylactic treatment (e.g. antiretroviral drugs to prevent HIV infection), which the doctors feel ethically obliged, and are able, to provide. In emergency cases where doctors are faced with a dual loyalty conflict between the demands of their employers and the interests of their patients the latter should prevail, irrespective of the pressure exerted on them by their employers.[10] For instance, it has been said that: 'It is unacceptable for doctors, in whatever field, to be overruled by management decisions which discount medical opinion and do not reflect patients' best interests'.[11]

Doctors may not allow their clinical independence to be compromised by unethical or unlawful directives from the authorities. Any doctor who ignores the ethical principles of the medical profession may face disciplinary action and may not rely on 'superior orders' from his or her employers as a defence[12] in the case of causing a rape survivor to become infected with HIV. Such a doctor will only be protected if the orders that he or she obeyed are themselves ethical.[12] Conversely, a medically qualified hospital or public official who issues directives that are contrary to medical ethics could be disciplined by the relevant professional disciplinary body for improper or disgraceful conduct.[13]

If a non-governmental organisation or pharmaceutical company makes the necessary antiretroviral drugs available for doctors or hospitals dealing with rape survivors, when the state does not provide such drugs, the doctors are ethically and constitutionally obliged to provide the necessary emergency medical treatment. Even if the public authorities issue a directive prohibiting such conduct, the doctors would still be ethically and constitutionally obliged to provide the treatment in accordance with good medical practice. The directive would be both unethical and unlawful and the doctors would be justified in ignoring it and stating the reasons for their conduct.

Any punitive action against a doctor seeking to act ethically and constitutionally would be unlawful and entitle the doctor to a court order preventing such action, or in the case of a dismissal from work, to reinstatement and damages for any loss suffered. Furthermore any medically qualified public official seeking to compel doctors to act unethically and unconstitutionally could be reported to the relevant disciplinary body for disciplinary action.

Duties of state hospitals

Where rape survivors present themselves for treatment at state hospitals and require immediate medical treatment to prevent them from contracting a fatal illness as a result of possible HIV infection, state doctors have no choice, no matter what the hospital or health officials direct. The Constitution is clear: 'Nobody may be refused emergency medical treatment'.[1] This imperative has also been recognised by the Cabinet.[2] The only basis for refusing such treatment would be if the public authority responsible for preventing doctors from providing prophylactic treatment to rape survivors could show that such refusal was 'reasonable and justifiable' in terms of the limitation clause of the Constitution.[14] Where non-governmental organisations or pharmaceutical companies have offered to make such treatment freely available to the state hospital, assuming that the concomitant treatment requirements such as counselling and follow-up are available, there would be no rational basis for preventing hospital personnel from providing rape survivors with prophylactic treatment against HIV infection.

In the past the Constitutional Court has held that where there is a scarcity of resources the courts 'will be slow to interfere with rational decisions made in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters'.[3] The Court has demonstrated that it will not hesitate to interfere where public authorities have not proved that their resources are so limited that they cannot provide the treatment requested, as in the case of the provision of antiretroviral drugs to prevent mother-to-child transmission of HIV/AIDS.[15]

Occupational post-exposure prophylaxis (PEP) is widely recommended and used. This, together with a growing body of related evidence in the areas of mother-to-child transmission and animal exposures, suggests the use following non-occupational exposures may be effective in reducing transmission. A prophylactic treatment against HIV infection should be given as soon as possible after the rape, but it may still be effective up to 72 hours after the incident.[16,17] Two-drug regimens appear to offer a reasonable safety profile. Before administration of the drugs, it would be necessary to ensure that the human immunodeficiency virus has not already infected the survivor. Hence it is recommended that the survivor be tested for the infection after pre-test counselling. Where negative, she is offered a 28-day course of zidovudine and lamivudine. Information-sharing with the survivor should include *inter alia* that PEP efficacy for sexual assault is unknown, that it is still under study, and that it is not yet licensed for rape prophylaxis. Common side-effects of PEP and the importance of compliance also need to be discussed. Survivors of child-bearing potential should be informed that the safety to the fetus in the first trimester cannot be guaranteed although PEP has not been shown to be teratogenic.

If a state hospital fails timeously to provide a rape survivor with the necessary antiretroviral drugs, or to refer her to the nearest facility that can provide such drugs, to prevent her from contracting HIV, the survivor can sue the hospital authorities and the state for damages for pain and suffering, loss of life expectancy, loss of income and any medical expenses incurred as a result of such infection. If such damages arise as a result of a failure to implement the government's antiretroviral programme for rape survivors, the state hospital will be liable unless it can show that such failure to do so was reasonable and justifiable.

Duties of private hospitals

Private hospitals do not have to accept anyone as a patient unless it is a medical emergency. Given that a rape survivor requires urgent medical treatment, what should private hospitals be required to do? In emergency cases the least that private hospitals will be required to do is to stabilise the patient until he or she can be transferred to a public hospital or clinic if the person is unable to afford private treatment or is not a member of a medical aid scheme. The same should apply to rape survivors, which means attending to their immediate needs.

If the time limit of 72 hours after the rape is about to expire, the private institution must contact the police, provide counselling, deal with the medical examination, conduct the HIV testing and provide the initial HIV prophylactic treatment. Once the survivor's immediate needs have been attended to, the police should be requested to collect and transport her to a public health facility for ongoing care. Under no circumstances should the private institution simply turn a rape survivor away, nor should she be kept waiting for an unreasonable period of time until the police arrive or before she is transported to a state hospital. Such a delay may constitute negligence on the part of the private hospital if it jeopardises the patient's access to prophylactic treatment. If unreasonable delays are likely, the private institution should arrange for the necessary transport to a state hospital. However, if the survivor desires ongoing care at the private institution, and can afford it, this should be provided.

Where a rape survivor is negligently kept waiting at a private institution so that it is no longer practicable to provide her with prophylactic treatment to prevent HIV infection, and she subsequently contracts the virus, she may have an action against the private hospital for pain and suffering, loss of life expectancy, loss of earnings, and future medical expenses. In other words legal liability will be imposed on private hospitals that negligently omit to treat rape survivors expeditiously or to refer them timeously to public institutions for emergency prophylactic medical treatment against HIV infection.

Role of non-governmental organisations

Non-governmental organisations have played an important role in supplementing the services provided to rape survivors by the state, particularly where the state lacks the resources or capacity to deliver such services. It is trite that in a medical emergency, where there are no trained medical personnel available, ordinary people may render first aid and emergency medical treatment.[7]

In the case of a non-governmental organisation that offers support and counselling to rape survivors, as well as HIV testing and antiretroviral treatment, in a province where the state does not provide such services to poor people, the legal position appears to be as follows: A rape survivor is entitled to emergency medical treatment[7] and it is necessary to test the person's HIV status before providing prophylactic anti-retroviral treatment. If the provincial hospitals do not offer preventive treatment, a non-governmental organisation may provide the pre- and post-test counselling and testing service even if its personnel are not medically qualified, provided that they have been properly trained in pre- and post-test counselling and rapid HIV testing. The fact that they undertake work reserved for the medical profession is not unlawful in this situation as the need to determine the HIV status of a rape survivor before providing prophylactic treatment is a medical emergency and no qualified medical personnel are available to provide the service. The reasons for the hospital authorities not providing the necessary emergency services are immaterial. If such services are not provided by the hospital authorities they may be provided by properly trained non-governmental organisation personnel.

Where attempts by a non-governmental organisation to offer emergency HIV testing and prophylactic treatment to rape survivors are obstructed or prohibited by hospital or health officials in a province that is not providing such testing and treatment, any rape survivor who as a consequence becomes infected with HIV would have a legal action for damages against them. Such damages would include pain and suffering, reduced life expectancy, loss of earnings and future medical expenses. Furthermore, when hospital or public officials issuing such directives are medically qualified, they may face disciplinary action by the relevant professional disciplinary body on the basis of negligently or intentionally preventing rape survivors from receiving emergency medical treatment.

1. Constitution of the Republic of South Africa Act 108, 1996: Bill of Rights s 27(3).
2. Bateman C. Sibongile Manana determined to lose grip. *S Afr Med J* 2002; **92:** 490-491.
3. *Soobramoney v Minister of Health, KwaZulu Natal* 1998 (1) SA 765 (CC) 774.
4. *R v K* 1958 (3) SA 420 (A) 421.
5. *Minister of Police v Skosana* 1977 (1) SA 31 (A).
6. McQuoid-Mason DJ, Dada MA. *Guide to Forensic Medicine and Medical Law*. Durban: Independent Medico-Legal Unit, 2000: 58-59.
7. McQuoid-Mason DJ, Strauss SA. The medical profession and medical practice. In: Joubert WA, Faris JA, eds. *The Law of South Africa*. Durban: Butterworths, 1999; **17:** par 182, 195, 203.
8. Constitution of the Republic of South Africa Act 108, 1996: Bill of Rights s9.
9. *Magware v Minister of Health* 1981 (4) SA 472 (ZA).
10. McQuoid-Mason DJ, Pillemer B, Friedman C, Dada M. *Crimes Against Women and Children: A Medico-Legal Guide*. Durban: Independent Medico-Legal Unit, 2002: 109.
11. British Medical Association. *The Medical Profession and Human Rights: A Handbook for Changing Agenda*. London: Zed Books, 2001: 106.
12. McQuoid-Mason DJ. The responsibility of doctors during the state of emergency. *Acta Juridica* 1988: 65-106.
13. Health Professions Act 56 of 1974: s 41(1).
14. Constitution of the Republic of South Africa Act 108, 1996: Bill of Rights s 36(1).
15. *Minister of Health and Others v Treatment Action Campaign* 2002 Case CCT 8/02 (unreported) par 135.
16. Tsai CC, Emau P, Follis KE, *et al*. Effectiveness of postinoculation (R)-9-(2-phosphonylmethoxypropyl) adenine treatment for prevention of persistent simian immunodeficiency virus SIVmne infection depends critically on timing of initiation and duration of treatment. *J Virol* 1998; **72:** 4265-4275.
17. Otten RA, Smith DK, Adams DR, *et al*. Efficacy of postexposure prophylaxis after intravaginal exposure of pigtailed macaques to a human-derived retrovirus (human immunodeficiency virus type 2). *J Virol* 2000 ; **74:** 9771-9775.