Colonialism, Biko and AIDS: Reflections on the principle of beneficence in South African medical ethics

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A R T I C L E   I N F O

A B S T R A C T

This paper examines the principle of beneficence in the light of moral and epistemological concerns that have crystallized in the South African context around clinical care. Three examples from the South African experience affecting the development of bioethics are examined: medical colonialism, the death in detention of Steve Biko, and the HIV/AIDS epidemic. Michael Gelfand's book [(1948). *The sick African: a clinical study*. Cape Town: Stewart Printing Company.] on African medical conditions captures the ambiguous nature of colonial medicine that linked genuine medical treatment with the civilizing mission. Biko's death was a key historical event that deeply implicated the medical profession under apartheid. The present HIV/AIDS epidemic presents the gravest social and political crisis for South African society. All three experiences influence the meaning and relevance of beneficence as a bioethics principle in the South African context. This paper argues for a South African bioethics informed by a critical humanism that takes account of the colonial past, and that does not model itself on an "original wound" or negation, but on positive care-giving practices.

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In time, we shall be in a position to bestow on South Africa the greatest possible gift – a more human face.

Steve Biko (1978). "Black consciousness and the quest for a true humanity." In *I write what I like*.

Introduction

A renewed interest in bioethics has occurred in South Africa simultaneous to the democratic transition from a racially dominated society. Solly Benatar and Willem Landman have recently noted that even though South African bioethics has by and large responded to the same forces as elsewhere, most notably the United Kingdom and the United States, it has also been molded by some uniquely South African experiences. In particular, they write, "the death of Steve Biko (the Black Consciousness leader), the HIV/AIDS pandemic, and a peaceful transition to democracy with increased focus on human rights have given bioethics in South Africa its own dimension" (Benatar & Landman, 2006, p. 239). While correct as a *prima facie* observation, Benatar's and Landman's statement assumes that bioethics is a stable entity developed through international experience and that sifting through this experience leads to the emergence of generalizable

principles more or less universally applicable to individuals and institutions. It assumes that there is a universal subject of bioethics, albeit characterized by different shades or nuances depending on the particular national and historical context. However, by assuming a universal subject, bioethics may be implicated in the same fixing and reifying of a "natural" self as the biological and medical disciplines to which bioethics normatively refers. Yet, the status of the South African subject of bioethics is largely still to be determined. Just observe the surprising dispute around the definition, let alone the treatment of HIV/AIDS that has crystallized around the former South African President, Thabo Mbeki's, alleged AIDS denialism. Mbeki's association with well-known AIDS denialists, and the consequent effects of stalling a massive rollout of anti-retrovirals (ARVS), mobilization by civil society, particularly the Treatment Action Campaign (TAC) for effective medical treatment of AIDS, have politicized a medical syndrome and medicalized the South African political landscape (Crewe, 1992; Epstein, 1996; Fassin, 2007; Fourie, 2006; Nattrass, 2007). Ordinary acts of citizenship in South Africa are caught up in a bio-politics of survival (Comaroff, 2007; Mbembe, 2003). In this way South African bioethics is by no means limited to a professional discourse, but is itself the subject of political critique by AIDS activists drawn from across the spectrum of South African society. Indeed, the South African subject of bioethics is constituted through this struggle, and by others, such as the previous struggle against apartheid, that

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together shape the particular South African socio-political landscape.

The analysis of the South African subject of bioethics provides a base from which to question the assumption of a universal subject of bioethics. The remarkable success of bioethics in establishing itself as a professional discipline over the past five decades can be associated with its ability to disguise the socio-political nature of its project through ascribing universal norms and a universal subject. This most notably is in the guise of the four principles of bioethics: autonomy, beneficence, non-maleficence and social justice (Beauchamp & Childress, 1979). Some Western bioethicists assume that these four principles hold universally and that to deny them, through a call for cultural difference most notably, means condoning barbaric practices such as female genital mutilation and espousing moral relativism (Macklin, 1998). Yet, in South Africa the specificity of individual bioethics subjects – subject to illness, the interventions of medicine, medical research and the protective measures of bioethics – necessitate the risk of local responses that are equally "rational" to their Western counterparts, though they may appear "irrational" in challenging, at the very least, the hierarchy, of these four established bioethics principles. In the South African socio-political landscape this becomes the problem of critiquing a 'rational' neo-liberal discourse characterized by disguising the socio-political nature of its interventions, without falling into the trap of the 'irrational,' epitomized by Mbeki's 'Africanist' position on AIDS.

This problem is exemplified by the question of the principle of beneficence, defined as the moral obligation arising from the professional practice of medicine to contribute to the welfare of one's patients through actively conferring benefits and removing harms (Beauchamp & Childress, 1979). For Thomasma and Pellegrino, two prominent philosophers of medicine, medical beneficence is not merely an ethical principle, but an inalienable aspect of the process of clinical reasoning. They claim that:

> Beneficence becomes a requirement not of a system of philosophy applied to medicine, but of the nature of medical activity. Respect for autonomy is required to achieve the ends of medicine because to violate the patient's values is to violate his person and, therefore, a maleficent act that distorts the healing end of the relationship… (Pellegrino & Thomasma, 1993, p. 53)

This gold standard of the medical profession is eminently reasonable. Yet, in the South African context, medical beneficence was complicated by its association with the civilizing colonial mission, and by implication with an oppressive system. Its ethical content has therefore been compromised by being co-opted into an instrument for colonial rule. This argument is similar to the critique of medical beneficence as a cloak for medical power (Veatch, 1999, 2002). Instead of dismissing the principle of beneficence out of hand, what is required in the postcolonial context is a reinterpretation of its empirical, historical and philosophical connotations (Mbembe, 2001).

This paper examines beneficence in relation to three examples from the South African experience: medical colonialism, the life and death of Steve Biko and the HIV/AIDS pandemic.[1] Michael Gelfand's book on African medical conditions entitled The sick African: a clinical study, captures the ambiguous nature of colonial medicine. Biko's death was a key historical event that deeply implicated the medical profession under apartheid. While much has been written about Biko since his death thirty-one years ago, including as a case study in medical ethics (McLean & Jenkins,

2003), there has been surprisingly scant philosophical attention to Biko. Re-analyzing the "Biko case" as it has become known provides the philosophical key linking the principle of beneficence with the South African history of medical colonialism and the present HIV/AIDS pandemic. All three examples influence the meaning and relevance of beneficence as a medical ethics principle in the South African context.

Bioethics trouble: a genealogical approach

Before knowing what bioethics principles are applicable in a South African context, South African bioethics needs to (re)discover a South African subject that could not surface under the ancien regime, through taking cognizance of its colonial and apartheid past influencing its post-apartheid present. In studying its formation it is necessary to trace the impact of the historical background of colonialism and apartheid as well as contemporary forces of neo-liberalism and globalization. The quest to determine the South African subject of bioethics through an analysis of beneficence requires a "genealogical" approach. In using this method to analyze the subject of gender, Judith Butler (1990) notes that, "juridical subjects are invariably produced through certain exclusionary practices that do not "show" once the juridical structure of politics has been established" (Judith Butler, 1990, p. 2). The formation of bioethics and juridical subjects are analogous in their political formations, though bioethics is often described as pertaining to issues that law cannot reach, i.e., at the margins of juridical structures. In this sense, bioethics structures may lie even closer to exclusionary practices than juridical ones.

This genealogical approach is obviously indebted to Michel Foucault's studies of discursive power structures:

> To expose the foundational categories of sex, gender, and desire as effects of a specific formation of power requires a form of critical inquiry that Foucault, reformulating Nietzsche, designates as "genealogy." A genealogical critique refuses to search for the origins of gender, the inner truth of female desire, a genuine or authentic sexual identity, that repression has kept from view; rather, genealogy investigates the political stakes in designating as an origin and cause those identity categories that are in fact the effects of institutions, practices, discourses with multiple and diffuse points of origin. (Butler, 1990, p. viii)

Following this method, this analysis provides a genealogical reading of the ontological structures of the three fundamental South African experiences for bioethics already mentioned. The task here is to make problematic the question of a subject of bioethics through mobilizing its constitutive categories in relation to bioethics. As with Butler, this approach does not deny the possibility of individual agency, but argues rather that the medical and bioethics subject arises from "practices of signification," and do not precede them as an ontological entity. Rather than seeking to reify particular concerns, such as the tension between the individual and the social good, into fixed categories, this analysis attempts to enter them into juxtaposition. The relation between dichotomies such as freedom versus oppression, the individual versus the social, and fact versus value finds new nuances in the African context.

This approach shares resemblance to the Foucauldian anthropological approach that analyzes the construction of colonial imperial subjects through dispersed disciplinary regimes (Butchart, 1998; Stoler, 1995; Vaughn, 1991). Foucauldian analysis of South African colonial medicine provides an exemplary demonstration of this method. However, my approach differs fundamentally from a 'pure' Foucauldianism in seeking to develop an African humanism through the face-to-face clinical encounter. While the particular

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[1] Two other key experiences which cannot be fully addressed in this paper include human rights and the South African epoch of social medicine.

legacies of colonialism and apartheid are obviously negative in their dehumanization of the face of the African other, they also have established an ethical structure important to consider for the development of a South African bioethics. The specifically South African context of these three examples provides an African moral image around which South African bioethics concerns crystallize. The purpose of this 'humanistic genealogy' is to overcome a negative structure that characterizes writings on African subjectivity. Mbembe (2002) observes that two narratives on African identity, Nativism and Afro-radicalism, have emerged from the practice of Marxism and nationalism in the twentieth-century. The result of these narrative structures is that the African subject "cannot express him- or herself in the world other than as a wounded and traumatized subject" (Mbembe, 2002, p. 630). The attempt to overcome this tendency, though only ultimately to affirm it, arguably characterizes Mbeki's tragic response to the HIV/AIDS pandemic. Beneficence captures the ambiguity of the South African moment for the average subject of bioethics caught between a historical legacy of oppression, a present condition of economic want and disease, and a future promise of freedom achieved through curing/care-giving practices.

Medical beneficence and the legacy of colonialism

It is not surprising to associate medical beneficence with colonialism since medicine was an intrinsic component of the missionary project (Vaughn, 1991). In referring to Protestant medical missionaries in Bechuanaland between 1820 and 1920, Comaroff and Comaroff (1997) note the fundamental ambiguity as well as liminality that characterized colonial healing from its inception. "For it was in the domain of healing that the distances and distinctions of the imperial frontier were most often breached; that all parties to the long conversation seemed most receptive to innovations from 'the other'" (Comaroff & Comaroff, 1997, p. 323). While the image of colonialism is not monolithic (Comaroff, 1989), it is possible to trace a continuity in the structure of the early period of colonial medicine right up to Mbeki's response to HIV/AIDS. For this discussion I refer to *The sick African: a clinical study* by Gelfand (1948), a South African trained medical doctor and anthropologist who conduced much of his work in Zimbabwe. Gelfand's study is relevant for its graphic depiction of the binary structure within colonial medicine, even as it transformed away from missionary healing into Western scientific medicine. While Gelfand's book refers to the experience of colonial medicine in Zimbabwe, it is of equal relevance for the South African context. This is due, firstly, to the fluid transmission of both the bodies of migrant laborers and medical concepts between South Africa and Zimbabwe. More importantly, Gelfand's book confirms my own personal experiences of the ambiguity of South African medical beneficence working in a provincial hospital in the Eastern Cape in the mid-nineties. While the postcolonial South African context is more nuanced than a simple binary structure, the ambiguity within beneficence as a form of colonial command still forms the basic structure upon which other medico-ethical, legal- and societal structures are overlaid.

In his study, Gelfand described two types of African patients, the so-called 'sophisticated' and 'unsophisticated.' The sophisticated African patient has begun to adopt the habits of Western civilization. "The vast majority of Africans are unsophisticated," he writes:

> They live in their reserves, and seldom come into contact with the white man. Their villages are badly planned and are often situated in malarial or tsetse-fly areas. They know nothing of the importance of taking precautions against disease. They have no idea of cleanliness, and their huts are breeding-grounds for

parasites and germs of every kind. Of sanitary arrangements they know nothing at all. They wash and bathe in the rivers in which they deposit their excreta, thus continually infecting themselves with bilharziasis. Their methods of agriculture are very poor, primitive, short-sighted and often disastrous, with the result that drought and famine frequently supervene. As a whole, their diet is extremely poor, consisting mainly of maize and other starchy cereals. Avitaminosis is common. Their resistance to infective diseases is weak... (Gelfand, 1948, p. 3)

As a classical clinical manual for rural practitioners of its time Gelfand's book provides testimony about the structure of colonial prejudice associated with beneficence that continues in a transmuted form in the postcolonial context. The concomitant photographs of African patients taken from Gelfand's study illustrate the depth of association made between 'Africanness' and severe pathology. Their disturbing visual imagery records and enacts the violation of the human condition under colonialism and then apartheid. It is the very pathologization of the face of the African that calls for a redemptive beneficence. Thus, beneficence and pathology are opposite sides of the same colonial logic. While Gelfand's book is an excellent clinical manual, it is precisely its excellence that gives impetus to its problematic conflation of beneficence and colonial power. Medical beneficence here is similar to the colonial violence crystallized in the concept of *commandement*, described by Mbembe (2001) in his study of the francophone post-colony. Thus, colonial paternalism reinforced the master–slave relation and "had no compunction about expressing itself behind the ideological mask of benevolence and the tawdry cloak of humanism." (Mbembe, 2001) This double trope of beneficence as care and as command was confirmed repeatedly during my internship in the Eastern Cape during the mid-nineties during the dying days of apartheid. Whether it related to the difference of hospital conditions for Black and White patients, or the vexed question of the frequent nurses' strikes, or the pseudo-African accent with which otherwise hard working doctors poked fun at the nurses who phoned with the news that "the patient is gasping, Dr.," the ambiguous structure of medical beneficence under apartheid characterized almost every clinical interaction. The most obvious example of this structure was encapsulated in the quick slaps that emergency doctors sometimes gave to their drunk patients who would not lie still as they attempted to stitch closed their fresh stab wounds. Here beneficence and command united in a single physical act of force to cure and contain the wild patient.

In his Foucauldian study of European constructions of the African body, Butchart (1998) notes how Gelfand in the third edition of *The Sick African* (1957) extended the range of physical pathologies that doctors should examine within the African to include "psychological disorders." For Butchart, this is evidence of the increasing Western capillary structure of disciplinary power over its African subjects. While there is undoubted truth to Butchart's claim, it is not the whole story, because it denies the African subject any real individual agency. This perspective denies the possibility of an African humanism and relegates the development of an African subject purely to forces of social domination.

Steve Biko (1946–1977)

Despite the "long conversation" between colonizer and colonized in which beneficence as a form of colonial command is embedded, the forces that animate it culminate and begin to unravel through the life and death of the leader of the Black Consciousness movement, Steve Biko. Biko's emphasis on psychological liberation presents a means of reconceptualizing African

subjectivity that is not limited to Foucauldian anatomy of power in the production of the colonial self.

The details of the Steve Biko affair, as it has come to be known, have been well described. In brief, Steve Biko, a formidable anti-apartheid student leader and intellectual exponent of Black Consciousness died in detention in 1977 at the hands of the state security police. Implicated in his death were the doctors, Ivor Lang and Benjamin Tucker, two district surgeons who were called to examine Biko after he had sustained severe head injuries. As has been recorded in detail, these medical doctors were complicit in failing to examine Biko properly, falsification of the medical notes, and conceding to the police plan of sending him on a fatal 750-mile journey to a prison hospital, where he was dead on arrival. (Baxter, 1985; Hoffenberg, 1994; McLean & Jenkins, 2003; Silove, 1990) Following Biko's death the Medical Association of South Africa (MASA) and the South African Medical Dental Council (SAMDC), now replaced by the Health Professions Council of South Africa (HPCSA), attempted to absolve Tucker and Lang from professional wrongdoing. Subsequently, MASA was thrown out of the World Medical Association (WMA), and the SAMDC was forced to perform another inquest in 1985 into the circumstances around Biko's death following the successful ruling by the Supreme Court in favor of a petition by a small group of doctors to hold a new inquiry into the allegations of improper or disgraceful conduct by Drs. Lang and Tucker.

The death of Steve Biko has become the most important single example of the violation of medical ethics under apartheid. The ethical implications of the case were readily apparent as summarized at the time in an editorial in the Rand Daily Mail.

> *It leads [to]… the inescapable conclusion that because Mr. Biko was black, a political activist and a Security Police detainee, his life as a medical patient somehow mattered less. It makes mumbo-jumbo of fine phrases of the Hippocratic Oath, phrases which apparently do not preclude doctors in such cases from filling in false medical certificates or ignoring serious signs or from leaving a patient naked, urine-soaked, manacled… or from being driven 1100 km through the night in the back of a Landrover.* (Editorial, *Rand Daily Mail*, 19 June 1980, quoted in Pityana, 1991)

More recently McLean and Jenkins (2003) have analyzed the Biko affair as a case study in medical ethics. They analyze the wrongs that occurred and the moral issues that emerge at the level of the individual physicians, and professional collective. They conclude their study by stating that:

> In all this, what is at stake is the nature and spirit of the true doctor–patient relationship. This relationship depends upon which commitment to provide uncompromised medical care that stands at the heart of the profession of medicine (McLean & Jenkins, 2003, p. 95).

From a health and human rights perspective, Baldwin-Ragaven, de Gruchy, and London (1999) have summarized what they perceive to be the key health and human rights issues that were raised by Steve Biko's death:

- District surgeons subordinated the interests of their patients to what they perceived to be those of state security, and were uncritical of their role and misinformed of their powers.
- The SAMDC, a body established by statute as the moral custodian of the medical profession, effectively condoned medical complicity in torture (by repeatedly failing to censure medical professionals who participated in abuse of detainees), thus colluding in the death of the victim.
- The organized medical profession, through its representative body, MASA, closed ranks in support of colleagues who colluded with the security police in the torture and death of detainees. MASA also attempted to silence and discredit those doctors who stood up for human rights and who demanded disciplinary action against their colleagues.
- Small groups of dedicated individuals had to resort to the Supreme Court to force the SAMDC to discipline the doctors after it had evaded its statutory responsibility for seven years (Baldwin-Ragaven et al., 1999, pp. 99–100).

While there were, of course, many ethical abuses perpetrated by South African health professionals under apartheid, documented for example in the Health and Human Rights Programme's Submission to the Truth and Reconciliation Commission, the death of Steve Biko was the watershed moment in the history of South African bioethics. It marked the moment when the mainstream health establishment profession could no longer pretend they were not in collusion with the apartheid regime. Biko's death was iconic for the moral degeneration of the health profession under apartheid. In order to understand more fully the continuous significance of the Biko case for bioethics, it is crucial to analyze the case. The medical circumstances, ethical and human rights dimensions of the Biko case have already been unpacked. Surprisingly, in light of all the attention and writing done on Biko, there is still space for a philosophical analysis of Biko's life and death.

It appears obvious to state that Biko continues to be of vital interest for South African medical ethics, both because of the medical circumstances surrounding his death as well as his intellectual and political stature. Yet, this deserves further elaboration. As the head of the Black Consciousness movement Biko was a public figure and the most articulate spokesman of his generation against racial oppression in South Africa. His death galvanized opposition to the apartheid regime within South Africa and abroad. The importance of Biko for bioethics, however, lies in the combination of his formidable intellectual contribution with the shameful manner of his death. The central tenet of Black Consciousness as developed by Biko was the necessity of psychological liberation from the shackles of racism. Biko understood that the political struggle to liberate all South Africa from apartheid as well as its prior colonial legacy, first and foremost required a mental liberation. Black Consciousness understood that the real power of oppression was volitional and psychological. The corollary of this is the understanding that political oppression is ultimately powerless against the human will. Additionally, as Biko (1978) claimed, his leadership of the Black Student Society (BSS) out of the largely White administered student body, NUSAS, was not meant as a racist act, but as libratory for both Black and White students.

The asymmetry between Biko's intellectual and moral height and the degradation of his death is captured in the resistant pathos of Biko's question to his interrogators, having it on record that he asked, "Is it compulsory that I have to be naked? I have been naked since I have been here?" (Essa & Pillai, 1977) Biko's question can be interpreted both as a request to be clothed, but also as an interrogative statement of resistance arising *from* his nakedness. Biko's absolute vulnerability as a naked, defenseless man established his absolute moral ascendancy over his oppressors. The moral outrage against Tucker and Langs' blindness of their duty to their patient Biko is explained by their decision to ignore this ethical responsibility arising from Biko's absolute vulnerability. The bioethics and human rights notion of professional dual loyalties articulated in response to abuses of this kind provides the legalistic language for what is a profounder issue of moral responsibility towards one's fellow human being.

This reading of Biko finds resonance with the ethical philosophy of Emmanuel Levinas, who through his reflections on the relation between freedom and vulnerability is particularly relevant for a redemptive analysis of the Black experience of bondage (Mbembe,

2004). In his first major philosophical work, *Totality and Infinity*, which articulates an ethical theory based on the phenomenology of the face, Levinas (1991) argues that the face of the "*Other*" while in one sense a graspable object in the world, a "thing among things," resists possession. "For the resistance to the grasp is not produced as an insurmountable resistance, like the hardness of the rock against which the effort of the hand comes to naught, like the remoteness of a star in the immensity of space" (Levinas, 1991, pp. 197–198). This dualism within the sensible appearance of the face explains the temptation and simultaneous impossibility of murder. The act of murder exercises power over the human face, which in its ethical transcendence escapes the power of annihilation. Levinas' paragraph has such uncanny resonance to Biko's humiliation and death that it is worth quoting here in full:

> The Other who can sovereignly say *no* to me is exposed to the point of the sword or the revolver's bullet, and the whole unshakable firmness of his "for itself" with that intransigent *no* he opposes is obliterated because the sword or the bullet has touched the ventricles or auricles of his heart. In the contexture of the world he is a quasi-nothing. But he can oppose to me a struggle, that is, oppose to the force that strikes him not a force of resistance, but the very *unforeseeableness* of his reaction. He thus opposes to me not a greater force, an energy assessable and consequently presenting itself as though it were part of a whole, but the very transcendence of his being by relation to that whole; not some superlative of power, but precisely the infinity of his transcendence. This infinity, stronger than murder, already resists us in his face, is his face, is the primordial *expression*, is the first word: "you shall not commit murder." The infinite paralyses power by its infinite resistance to murder, which firm and insurmountable, gleams in the face of the Other, *in the total nudity of his defenceless eyes, in the nudity of the absolute openness of the Transcendent.* [Italics mine] There is here a relation not with a very great resistance, but with something absolutely other: the resistance of what has no resistance – the ethical resistance (Levinas, 1991, pp. 198–199).

Drawing on Levinas it is plausible to argue that Biko represents an historical example of the ethical imperative arising from the face of the Other. Biko's intellectual and volitional resistance to the oppressive forces of colonialism and apartheid rendered him immune to the forces of the apartheid state, yet his human fragility under torture established an ethical structure of transcendence that remains of importance for bioethics, and South African society more generally. Biko (1978) was correct in stating that his greatest gift would be to bestow on South Africa a more human face. It is this human face pointing to an ethical structure in the doctor–patient relationship revealed by Biko's death that serves as a model for South African bioethics. The ethical responsibility for the Other arising from the face-to-face relation explains why the principle of beneficence lies at the heart of the doctor–patient relationship. The asymmetry of power in the clinical encounter institutes the demand for beneficence that characterizes the ethical foundations of the doctor–patient relationship generally, and especially in the South African context. Thus, the requirement in the light of the recognition of this colonial heritage is to recognize a qualified 'double principle' of beneficence that responds to the vulnerability of historically disenfranchised patients, and that is always conscious of the material conditions in which it functions. Because of South Africa's particular colonial and apartheid history, health providers need to take extra care that this medical beneficence does not become misused and transmute into gross medical paternalism, a betrayal of the ethical imperative arising from the doctor–patient relationship. However, beneficence in the South African context needs to uncouple its ethical dimension from its colonial past. While necessary, this 'double principle' of beneficence is also problematic as the basis for forging a South African subject of bioethics, because it is premised on vulnerability, and thereby maintains identity in relation to an original wound. In the postcolonial moment, this wound has further festered as a result of the HIV/AIDS pandemic.

The South African HIV/AIDS pandemic

South Africa lies at the heart of the HIV/AIDS pandemic that began in the early 1980s. According to the latest Joint United Nations Program on HIV/AIDS (UNAIDS, 2006), there are approximately 5.5 million persons infected with HIV, and an HIV/AIDS prevalence rate of 18.8%. The tragedy of the pandemic is especially bitter, coinciding with South Africa's transition to democracy. Moreover, the ANC Government's response to the epidemic has been compromised by former President Mbeki's apparent support for AIDS denialism and clear opposition to treatment with ARVS. A recent study by a group of Harvard researchers estimates that more than 330,000 lives were lost because a feasible and timely ARV program was not implemented (Chigwedere, Seage, Gruskin, Lee, & Essex, 2008). This issue is hopefully of historical interest only, since the deposition of former President Thabo Mbeki, and the new Minister of Health, Barbara Hogan, has indicated that the era of South African AIDS denialism is over (Dugger, 2008). Meanwhile, social activism around the issue of access to ARVS and contesting AIDS denialism has resulted in the emergence of novel forms of citizenship beyond the margins of state intervention and Western biomedicine (Mindry, 2008; Robins & von Lieres, 2004). Moreover, a kind of sympathetic understanding, if not support, characterizes some interpreters of Mbeki's attitude towards the HIV/AIDS pandemic in the name of resistance to colonialism (Fassin, 2007; Hoad, 2005; Wang, 2008). Articulating the meaning of beneficence in the South African landscape of HIV/AIDS requires skillful navigation between these divergent social and intellectual forces.

The HIV pandemic highlights the fact that autonomy is largely absent, both in regard to the sexual transmission of the HIV virus, as well as the biomedical response. Another South African bioethicist, David Benatar (2002, p. 394) argues that HIV-positive persons who contract or transmit the condition "through negligence, indifference, arrogance, or weakness" do not deserve to criticize the state for not providing adequate antiretroviral treatment. He bases this controversial position out of respect for the autonomy of competent adults in a society that protects civil and political rights. Yet the personal vulnerability associated with contracting HIV/AIDS does not negate, but affirms the importance of beneficence. Patient vulnerability, whether due to the HIV virus, or any other disease inducing mechanism, establishes a requirement for medical beneficence on the part of health professionals, irrespective of their particular prejudices or beliefs. In support of this argument, Solly Benatar (2006, p. 323) has noted the importance of the principle of beneficence in the context of AIDS, requiring that, "as many people as possible receive treatment, and the best possible outcomes be achieved". Clinical practice rooted in the principle of beneficence makes it very difficult for health practitioners to turn patients away, and necessitates the importance of palliative care when life-saving therapeutic options are either not possible or exhausted.

David Benatar's argument appears to continue the colonial practice of blaming vulnerable populations for the spread of contagion (Curtin, 1992; Swanson, 1977). Denying full civil rights to those infected with HIV because they have abrogated their full autonomy, without acknowledging the presence of social inequality in hindering individuals' capabilities may be associated with a neo-liberal moment that keeps in place societal forces of domination, while simultaneously claiming that the field of individual

opportunity has been equalized. Alternatively, the "opaque" or even "spectral" processes" of neo-liberalism establish a subject in which the personal and the political merge (Comaroff & Comaroff, 2000). The political crisis around HIV/AIDS treatment demonstrates the manner in which social inequality in the post-colony challenges legitimate power structures based on inclusion and equality among citizens (Mbembe, 2001). It is morally imperative in responding to this challenge not to blame vulnerable populations for their vulnerability. To do so, as Bauman (1993) notes is to deploy an ethical code as an instrument of social domination, and thereby justify moral heteronomy! While full autonomy is desirable for a strong civil society, it is naïve to believe that social behavior follows strictly utilitarian or deontological rational norms. The great irony of the South African HIV/AIDS epidemic is that the ontologically negative status of being "HIV Positive" as the proud banner on TAC t-shirts indicates, serves as an awakening to socio-political awareness and action. Hence, to some extent, the development of a full subject of South African bioethics, including having a sense of autonomy, in many individuals, follows and is not prior to a state of infection. The HIV virus, thus, deepens the original wound of colonialism in a postcolonial neo-liberal environment, but also produces means for therapeutic responses to it. Beneficence, with its structure of ambiguity, is an important though limited element of these therapeutic responses that together constitute a South African bioethics subject. In relation to HIV/AIDS, beneficence is transcended through the move from the individual to the social.

Whereas autonomy speaks to individual independence and beneficence to mutual dependence, the dyadic nature of the clinical interaction around HIV/AIDS is necessarily affected by larger social concerns. The often impossible decisions needing to be made by health professionals treating AIDS patients means a shift in the balance in the principles of medical ethics away from autonomy and beneficence to the principle of social justice, referring largely to the allocation of scarce resources. Indeed, the sheer scale of the epidemic means that the principle of beneficence "may both overshadow autonomy and thwart public health goals" (Benatar, 2006, p. 323). The principle of justice has risen to the fore because of the practical impossibility of treating all HIV patients with ARVS. Moreover, the dangers of multi-drug resistance arising from poor patient compliance may necessitate the practice of patient screening and selection. Accordingly, the human rights organization, *Mèdicine Sans Frontières* (MSF) in its first pilot ARV project in the Western Cape township of *Khayelitsha* has enacted a series of selection criteria based on medical, social and adherence factors (Fox & Goemaere, 2006; Oppenheimer & Bayer, 2007). Commenting on this phenomenon, Solly Benatar (2006, p. 326) argues that, "The public health necessity to prevent the emergence of multi-drug resistant HIV may justify overriding individual rights to treatment for those who may not be able to adhere to treatment long term and who will probably benefit minimally".

This emphasis on the principle of social justice is especially pertinent because it arises from actual experience in the clinical context, and not simply from a theoretical formulation of public health concerns. Concerns of justice may, in certain circumstances, over-ride both the concern for patient autonomy and the beneficence towards patients by health professionals. This is evidenced by the policy of MSF doctors not to outrightlly deny any patients treatment (Fox & Goemaere, 2006). Maintaining ties to the clinical encounter means that the process of 'patient selection' for ARVS remains a constantly renegotiated and traumatic experience, rather than simply following public health protocol. Thus, the 'state of exception' resulting from the ravages of the HIV/AIDS epidemic is constantly recognized or reenacted and does not simply become reduced to figural statistics, and the ethical principles merely

automatic heuristic devices. In this sense, bioethics principles are associated with health care practices that 'liberate life,' to use a term from the Brazilian anthropologist Biehl's (2007) study of AIDS and the politics of survival.

African humanism

While issues of social justice temper the other principles of autonomy and especially beneficence, there is another manner in which the negative aspect of beneficence in its colonial associations may finally be transcended through contact with the social; in other words, through the African humanist notion of *Ubuntu*, whereby a person becomes a person through social relationships. The notion of *Ubuntu* informed Biko's (1978) statement that, "In time, we shall be in a position to bestow on South Africa the greatest possible gift – a more human face." The genealogical construction of the South African subject of bioethics needs to mine this deep concept of African personhood. Yet, *Ubuntu* is complicated by its association with the justification of AIDS denialism in the name of African identity and resistance to colonialism. In his lecture to mark the 30th anniversary of the death of Steve Biko, Mbeki (2007) questioned the colonial association of Africanness with lasciviousness, an indirect reference to the sexual transmission of the HIV/AIDS virus. In contradistinction Mbeki posited Ubuntu as encapsulating the value system that Biko visualized:

> Why can't an African world view, such as Ubuntu, be at the centre so that we can view other cultures in relationship to it? Ubuntu, which reminds us that 'a person is a person through other people,' does not allow for individualism that overrides the collective interests of a community. It stands in contradistinction to the idea that an individual is the be-all and end-all, without, at the same time, positing that an individual is rightless or dispensable in the grand scheme of things (Mbeki, 2007).

There is not space to enter deeply into the question of former President Mbeki's attitude towards AIDS. It is important to state, however, that resisting colonialism in the name of an African humanism does not necessitate supporting AIDS denialism. Fassin (2007) suggests as much in attempting to grasp the particular rationality of Mbeki's thinking as a sociological interpretation of the epidemic, linking biological and social theories. Social epidemiologists, like Zena Stein and Mervyn Susser, who provided early warning about the HIV/AIDS pandemic, and who linked the social and biological sciences without denying the viral etiology of HIV/AIDS were alienated by Mbeki's association with AIDS denialists (Bayer & Susser, 2000). South African social medicine pioneered in the foothills of Kwazulu Natal in the late 1930s by the later Kark and Kark (1999) laid the foundations of the discipline of social epidemiology. A key aspect of their work was the study of African cosmology and conceptions of healing. Interestingly, Kark was aware of the similarities between social medicine in regarding the importance of cultural and social factors in the causation of disease and Zulu notions of witchcraft practices, commenting at one point that "witchcraft thinking is social thinking: a man examines his relations with other people: and the diagnosis and treatment are also in social terms … such an attitude to ill-health comes very close to our Western concept of social medicine" (quoted in Vis, 2004, p. 57). A colleague of the Karks', John Cassell better known as the founder of social epidemiology, pioneered studies demonstrating the relation between the management of tuberculosis and belief in African witchcraft (Cassell, 1962). Indeed, there are strong parallels between this research and more recent research by the anthropologist Ashforth (2005) into the South African HIV/AIDS epidemic. The principle of *Ubuntu* is important here, because it reflects a positive humanism arising from social

relationships, akin to African witchcraft practices, but without the latter's negative dehumanization of the Other (Bongbma, 2001).

Social epidemiology with its strong notions of multi-causal etiology of disease, including social relations and cultural beliefs, presented a socio-biological theory of the HIV/AIDS pandemic that could have been incorporated into a plausible African theory of HIV/AIDS. The effects of colonialism on the HIV/AIDS pandemic to name a few, includes local social practices, gender politics, community cohesion, economic livelihoods and access to medical care (Kalipeni, Ezekiel, Craddock, Oppong, & Ghosh, 2004). Butchart (1998) interprets the early South African social medicine movement as a deepening of disciplinary power amongst a rural African population. Yet, this Foucauldian reading denies the very real practice of care by this dedicated and politically conscious group of people and strips African actors of any meaningful sense of personhood (Jeeves, 2000). Additionally, this approach would also obviate personal responsibility in responding to the present HIV/AIDS pandemic. Nonetheless, the ambiguous structure of colonial medicine pervades the practice of social medicine at an individual and social level (Marks, 1997). One means of overcoming this original wound in effectively implementing the principles of beneficence and social justice in the South African context requires the combination of *Ubuntu* with critical reflection; combining beneficent care-giving practices with a constant genealogical analysis of the historical and socio-political forces that continue to animate South African individuals and society. The cost of avoiding this difficult balance is to fall into binary dichotomies represented by Mbeki's denialism and TAC activism, and to strip the South African subject of bioethics of either rationality or effective agency in the social world.

Acknowledgements

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