

**APART FROM MEDICAL EMERGENCIES, WHEN IS IT JUSTIFIED FOR
GYNAECOLOGISTS, AND OBSTETRICIANS TO DEVIATE FROM
INFORMED CONSENT WITHOUT REVERTING BACK TO THEIR
PATIENTS?**

By

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PREFACE

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SUMMARY

Medical care relies on a bond of trust between the patient and caregiver and on the patient's ability to make free and informed choices, to understand and guide the course of their care. Informed consent is the foundation of this trust, ensuring that the patient is adequately informed so as to best understand their options and decide their treatment path. Informed consent is an express legal mandate granted by a patient to a healthcare practitioner after consultation. The patient relies on the provided information when choosing to accept, reject, or seek to modify a proposed intervention. The patient is protected by Statutes that dictate the manner in which informed consent must be obtained, requiring that relevant information be provided in such a way that the patient understands the nature, intended effect, and risk or consequence associated with the intervention. In many cases, it must be established if the patient has the legal capacity to consent or not.

This research topic will consider how proper enforcement of informed consent practices, procedures, and the implementation of current policies and rules in gynaecology and obstetrics may prevent cases of gross negligence, unlawful assault or the compromising of patient rights under the Constitution, the common law and specifically, the criminal law.

The study aimed at:

1. Investigating under which circumstances, despite current legislation, policies and procedures, health practitioners choose and still adopt a paternalistic approach towards patients in their care in the field of gynaecology and obstetrics, which leads to deviations from the requirements of informed consent;
2. Obtaining explanations for cases where doctors, particularly in gynaecology and obstetrics, neglect patient autonomy and the need for informed consent, and are seen to deviate from their ethical and legal obligations, and actively make decisions that properly belong to the patients.

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Chapter 1: INTRODUCTION

1.1 The purpose of the study

Prior to the adoption of modern practices, the healthcare system used the paternalistic approach. Although doctors applied the principles of beneficence (best interest) and non-maleficence (no harm), when treating their patients,¹ they did not necessarily place importance on self-determination or consider the right to refusal. Typically, under the old paradigm, the doctor was exclusively involved in choosing the medical interventions for their patients, based solely on their expert knowledge and opinion, believing it to be in their patients' best interest, even if it was contrary to their immediate desires or freedom of choice.²

Marsh states that with the very long history of such practice by the medical fraternity, informed consent can be difficult for doctors to communicate and apply in person, to lay people in such a manner, and to communicate in such a way that the patiently understands sufficiently to make an informed decision.³ There is a need for education, training, communication skills and language proficiency within the medical fraternity. Further, the national and spoken language of the people of the community must be incorporated into the medical curriculum or the introduction of services of other professionals and translators must be engaged to aide communication.

Our current legal system requires patient autonomy and self-determination with exceptions only for specific circumstances.⁴ This policy reflects freedom of choice, and promotes and encourages patients to participate in a rational decision making process affecting their health status.⁵ Any interference with a treatment course or medical intervention made absent informed consent, without adequate reason is considered a 'violation of a person's right to control his own body'⁶ and rights to bodily integrity and security under the Constitution.⁷

¹ MA Dada and DJ McQuoid Mason *Introduction to Medico-Legal Practice* (2001) 36.

² A Dhai and DJ McQuoid- Mason op cit 14 at 69

³ BT Marsh op cit 34 at 35

⁴ Section 7 and Section 8 of The National Health Act 61 of 2003,

⁵ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 883 " Pivotal to the application of the doctrine of informed consent in South African medical law, is an understanding of the broader purpose and function of the doctrine. According to Van Oosten these are two fold: - to ensure the patient's right to self determination and freedom of choice; and – to encourage rational decision-making by enabling the patient to weigh and balance the benefits and disadvantages of the proposed intervention in order to come to an enlightened choice either to undergo or refuse it".

⁶ Stoffberg and Elliot 1923 CPD 128, also cited in P Carstens and D Pearmain: *Fundamental principles of South African Medical Law*, 879 at footnote 44: 'The plaintiff claimed 10 000 pounds in damages for assault. The Plaintiff was admitted to the hospital for surgical and medical treatment for cancer of the penis. Dr. Elliot, who treated the plaintiff was an honorary visiting surgeon who assumed the administrative procedures, including, the obtaining the patient's consent had been followed. He was doing charitable work at the hospital. The patient's

Informed consent requires more than just a signed form. It is a process which encompasses the medical practitioners' input whereby he/she provides recommendations; shares their reasoning for the chosen medical intervention(s) in lay person's terms, and at the same time assesses the patients' understanding thereof.⁸ Health professionals are expected to give the patient appropriate and adequate information, all pitched to their level of understanding.⁹ This ensures that 'adequate information becomes a requisite of knowledge, appreciation and acquiescence and, therefore, also of consent.'¹⁰

There is an implied duty by the doctor to examine and treat the patient with knowledge and skill, to work in the best interest of the patient and perform a variety of functions, including examining, diagnosing, formulating a treatment and/or prevention plan and to advise the patient on their diagnosis, on self-care, and to provide and explain medication when necessary.¹¹ A doctor who fails in their charge may be held liable for a breach of contract.¹²

The mere submission of the patient to a healthcare facility or a doctor in private practice does not imply that the patient has automatically consented to treatment.¹³ Neither is it indication that they waive their right to security of person, or to be involved in the decision-making process with respect to any medical interventions they might require.

A person, who goes to a hospital or treatment center for elective treatment, will contract with the doctor or delegated health personnel duly authorized to do so on behalf of the doctor, who will provide the treatment and care to the patient.¹⁴ As it is not always possible for the attending doctor to obtain the consent, he or she must ensure that the patient has been given sufficient time and all necessary information to make an informed decision about his or her medical treatment by a suitably qualified and trained delegate. It is problematic when either the delegated health professional or the attending doctor, namely does not comply with the HPCSA's guidelines on consent nor do they fully understand the risks and benefits of the

penis was surgically removed. The patient maintained that he had not given consent to the operation. The jury found for the defendant.”

⁷ Section 12(2)(b)The Constitution of the Republic of South Africa Act 108 of 1996.

⁸ Jessica De Bord, 'Informed Consent' Ethics in Medicine, University of Washington School of Medicine. Available at: bioethx@u.washington.edu (accessed 16 May 2015).

⁹ N.Hoppe and J.Miola op cit 40 at38.

¹⁰ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 879.

¹¹ N.Hoppe and J Miola op cit 40 at 38.

¹² L.C Coetzee and Pieter Carstens *Medical Malpractice and Compensation in South Africa* (2011) 86 *Chi-Kent.L.Rev.* 1263.

¹³ HPCSA Guidelines, *Seeking Patients' Informed Consent: The Ethical Considerations*, Booklet 9, para 15 (2008).

¹⁴ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 877.

proposed treatment.¹⁵ Within the public health sector, the state can be held vicariously liable for its employee's wrongful conduct as these employees act in the course and scope of their duties,¹⁶ during the delivery of the medical treatment and /or service.

The purpose of this study is to demonstrate and explore the tendency of gynaecologists and obstetricians to deviate from informed consent without reverting back to their patients, despite the existence of both legal and ethical imperatives to do so, in keeping with patient autonomy and right to informed consent. I will demonstrate that health care practitioners are still paternalistic and/or alternatively, have limited knowledge of legal principles, ethical guidelines and protocols regarding informed consent. Informed consent is of paramount importance to a woman's sexual and reproductive health and self-determination. When informed consent is neglected, the patient is deprived of the information or the opportunity to give or withhold consent for a given medical intervention. The fields of Gynaecological and obstetric are specialist services, involving sexual health and reproduction, which are particularly sensitive in nature and necessitates the greatest caution, and has a unique potential for lasting physical and psychological harm, for which legal recourse is a necessity.¹⁷ The objective of study is to show that South African case law on informed consent, South African legislation together with the Constitution to do not use a uniform standard of information disclosure. Comparisons of foreign common law jurisdictions like United Kingdom, India and Canada will illustrate how the courts in South Africa are indecisive and fluctuate between the reasonable doctor standard of information disclosure and the prudent patient standard of information disclosure in relation to international jurisprudence.

¹⁵ Booklet 9, Section 2. 1 of the HPCSA: *Seeking Patient's informed consent: The Ethical Considerations* (2008) guidelines state that: ' Successful relationship between health care practitioners and patients depend upon mutual trust. To establish that trust practitioners must respect patient autonomy- their right to decide whether or not to undergo any medical intervention, even where a may result in harm to themselves or in their own death. Patients must be given sufficient information in a way that they can understand, to enable them to exercise their right to make informed decisions about their care. That is what is meant by informed consent.'

¹⁶ D.Mcquoid-Mason 'Establishing liability for harm caused to patients in a resource-deficient environment' (2010) 100 (9) *SAMJ* 573.

¹⁷ Pepper MS , Slabbert MN 'Is South Africa on the verge of a medical malpractice litigation storm ?'(2011) 4:1 *South African Journal of Bioethics and Law* 29 'The Gauteng Department of health and Social development faced malpractice claims totaling R 573 million in 2009-2010. The largest payouts have been in obstetrics and gynaecology surgery.'

1.2 Methodology

A desktop research methodology approach was used to investigate and examine case law relating to violations of informed consent practices to women's sexual and reproductive self-determination. I compared cases, policies, procedures and the legislation of South Africa, against comparable legal and medical protocols in the United States, Namibia, the United Kingdom, Canada and India. Relevant materials from journal articles, textbooks, newspaper and other media assisted me to derive answers as to why practitioners in these essential women's services failed in their ethical duty to respect autonomy and informed consent laws; where the practitioner instead adopted a paternalistic manner of service and presumed to decide crucial medical matters without first consulting the patient whose self-determination should be guaranteed and whose informed consent was required.

I examined opinions that argued for exceptions and attempted to justify some of these cases. A broad and comparative evaluation of the argument including the views of legal writers, medical practitioners, researchers in the field, statutes and decided cases was reviewed to conclude under which circumstances, apart from a medical emergency, it is appropriate for a gynaecologist or an obstetrician to deviate from informed consent.

1.3 The value of the doctrine of informed consent, where the patient has the right to bodily integrity and self determination, and its relevance in medical law in South Africa

The doctrine of informed consent is enshrined in the Bill of Rights, in Chapter 2 of the Constitution of the Republic of South Africa.¹⁸ Although, a person's right to informed consent is not indicated in our Constitution, it can be inferred from rights such as the right to bodily and psychological integrity. The doctrine of informed consent is an ethical principle as well as a legal requirement for medical practice which is founded on core values of equality,¹⁹ human dignity,²⁰ life,²¹ freedom and security of the person,²² privacy,²³ freedom of religion, belief and opinion,²⁴ access to healthcare, food and water, social security,²⁵ as well as specifically enumerated reproductive and children's rights.²⁶ These rights are supported by the National Health Act,²⁷ the National Patients' Rights Charter²⁸ and the common law,²⁹ as

¹⁸ Chapter 2: Bill of Rights of The Constitution of the Republic of South Africa Act No 108 of 1996.

¹⁹ Section 9 (3) of The Constitution of the Republic of South Africa Act No. 108 of 1996: 'The state may not unfairly discriminate directly or indirectly against anyone on more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.'

²⁰ Section 10 of The Constitution of the Republic of South Africa Act No. 108 of 1996: 'Everyone has inherent dignity and the right to have their dignity respected and protected'

²¹ Section 11 of The Constitution of the Republic of South Africa Act No. 108 of 1996: 'Everyone has a right to life'

²² Especially section 12(2) (a) : 'Everyone has the right to bodily and psychological integrity which includes the right: (a) to make decisions concerning reproduction; (b) to security and control over their bodily; and (c) not be subject to be subject to medical or scientific experiments without their informed consent'

²³ In terms of Section 14 of The Constitution of the Republic of South Africa Act 108 of 1996

²⁴ Section 15 of The Constitution of the Republic of South Africa Act 108 of 1996

²⁵ In terms of Section 27 of The Constitution of the Republic of South Africa Act 108 of 1996, 'Everyone has the right to have access to health care services, including reproductive health care; section 27 (3) : 'No one may be refused emergency medical treatment.'

²⁶ Especially the S 28(2) of The Constitution of the Republic of South Africa Act 108 of 1996, which provides that the child's best interests are paramount in any decision concerning the child.

Section 28(1)(b) provides that children have the right to appropriate alternative care when removed from the family environment. It is submitted that this is especially pertinent in light of s 28(2) and the fact that children under the age of 12 cannot give decisive informed consent to any medical or surgical treatment other than a termination of pregnancy, see the Children's Act 38 of 2005 s 129(1). This is because 'appropriate care' in these situations, together with the best interests of the child requires anyone consenting to any medical care on behalf of the child to meet both these criteria. It is submitted that this argument is further supported by s 28(1)(c) which provides that children have the right to basic nutrition, shelter, basic healthcare services and social services. S 129 of the Children's Act 38 of 2005 states a child who is over the age of 12 and who displays sufficient maturity and has the mental capacity to understand both risks and benefits as well as social implications may consent to his or her own medical treatment. However, in the case of surgical medical intervention; the child must be assisted by a parent or guardian . Where the child does not satisfy the requirements of S 129 the parent or guardian can consent to the child's medical intervention or treatment. S 130 (1)(a) of the Children's Act provides that a child may consent to HIV tests if it is in the child's best interest and the child is older than 12 years. S 130 (2) stipulates circumstances where the child who is younger than 12 years of age and where he or she shows no maturity nor understanding of the risks , benefits or social implications of the HIV test, then the parent, guardian or provincial head of social, the head of the child protection institution or the superintendent of the hospital can grant consent. Lastly, the Children's Court can be approached if getting consent from previously mentioned sources prove futile.

²⁷ National Health Act no. 61 of 2003

²⁸ "Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects any one of these elements" <http://www.doh.gov.za/docs/legislation/patientsrights/chartere.html> (accessed 09-10-2017)

well as the guidelines published by the Health Professions Council of South Africa (HPCSA).³⁰ The HPCSA recognizes that the fundamental rights of autonomy and self-determination are pertinent to protecting individuals from medical procedures, interventions and treatments that require informed consent and risk otherwise, harming or disempowering the patient, violating numerous legal guarantees.

Given the wide range of medical presentations of patients, there are specific procedural requirements in section 7 of the National Health Act, 2003³¹ which codify the policies regarding treatment, medical intervention, and hospitalization of patients who cannot meaningfully consent, whilst best attempting to protect the constitutional rights of patients, such as their right to life, healthcare, reproductive rights and children's rights.³²

Although the law allows in certain situations, for medical practitioners to treat a patient absence of informed consent; these are applicable only:-

(a) by way of a court order, for example, the provisions of the Criminal Law (Sexual Offences and Related Matters) Amendment Act³³ provide that a person can be forced under court order, to surrender to blood testing for HIV, if the suspect is accused of committing a sexual assault. This Act makes provisions for the victim of the sexual offence /s or the officer investigating the alleged sexual offence to apply for a magistrate's order for the compulsory testing of the alleged offender.³⁴ It is important to note that these compulsory testing procedures are regulated by the Criminal Law Amendment Act³⁵ and not by the National Health Act,³⁶

(b) in terms of any law;³⁷

(c) when medical practitioners or authorities believe that failure to treat such a patient will result in a serious risk to the public;³⁸ or

²⁹ Raab E L, *The parameters of informed consent* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1280103/> (accessed 09-10-2017) 'Informed consent begins with consideration of the tort of battery, one of the oldest forms of legally disfavored conduct. It consists of unpermitted, unprivileged, intentional contact with another's person. The contact need not result in bodily harm; the intended contact itself is the harm.'

³⁰ Ames Dhair and David McQuoid - Mason *Bioethics, Human Rights and Health Law: Principles and Practice* (2011) 18: 'In South Africa, The Health Professions Council of South Africa (HPCSA), a statutory body in terms of the Health Professions Act 56 of 1974, is responsible for setting the standards for the ethical and professional conduct of practitioners registered with the Council.'

³¹ Section 7 of the National Health Act 61 of 2003,

³² As referred to in The Constitution of the Republic of South Africa Act 108 of 1996.

³³ Part 2: Section 30 of the Criminal law and Related Matters) Amendment Act No. 32 of 2007.

³⁴ Part 2: SS 30-31 of the Criminal law and Related Matters) Amendment Act No. 32 of 2007 .

³⁵ Criminal Law (Sexual Offences and Related Matter) Amendment Act 32 of 2007.

³⁶ Section 30(1) (a) of the Criminal law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007.

³⁷ Section 7 (1)(c) of the National Health Act 61 of 2003.

(d) where failure to render the necessary medical assistance will result in the death or irreversible harm to the patient.³⁹

The HPCSA further recognizes ethical concerns surrounding the health risks and wellbeing of the HIV positive patient's sexual partners especially in situations where the patient refuses consent to disclose their HIV status to their partner/s. In these situations, the health care practitioners are cautioned and guided in using their discretion to divulge the patient's HIV status to their sexual partners taking into account the risks following such disclosure, in respect of each patient.⁴⁰

But in many cases, there are no justifications available for ignoring consent laws. A medical practitioner will be liable for assault when a patient is wrongfully and unlawfully operated upon or treated by a medical practitioner without proper informed consent.⁴¹

This is a direct violation of the patient's constitutional rights of physical bodily integrity and security⁴² including their common law and constitutional rights to dignity⁴³ and privacy⁴⁴ more so than that being a violation of law's protecting patient's health.⁴⁵ Therefore it is not just interventions that can violate patient rights, but also the dissemination or collection of information; improperly obtaining information about a patient, breaching of doctor-patient confidentiality, blood testing or screening without the consent, all amount to an invasion of a patient's constitutional right to privacy.⁴⁶

³⁸ Section 7 (1) d of The National Health Act 61 of 2003.

³⁹ Section 7 (1) e of The National Health Act 61 of 2003; Pieter Carstens and Debbie Pearmain *Fundamental Principles of South African Medical Law* (2009) 18.

⁴⁰ HPCSA Guidelines for Good Practice with regard to HIV (2008) para 9.2: "If the patient refuses consent, the health care practitioner should use his or her discretion when deciding whether or not to divulge the information to the patient's sexual partner and the risks to the patient (eh, through violence) that may follow such disclosure. The decision must be made with great care, and consideration must be given to the rights of all parties concerned. If the healthcare practitioner decides to make the disclosure against the patient's wishes, the practitioner must do so after explaining the situation to the patient and accepting full responsibility at all times."

⁴¹ HPCSA Guidelines for Good Practice in the Health Care Professions, *Seeking Patient's Informed Consent: The Ethical Considerations*. Booklet 9 (2008) at 3.1.5: 'Health practitioners must not exceed the scope of the authority given by a patient, except in an emergency. Therefore, health care practitioners providing treatment or undertaking investigations must give the patient a clear explanation of the scope of consent being sought.'

⁴² Section 12(2)(b) of The Constitution of the Republic of South Africa Act No. 108 of 1996.

⁴³ Section 10 of The Constitution of the Republic of South Africa Act No. 108 of 1996.

⁴⁴ Section 14 of the Constitution of the Republic of South Africa Act No 108 of 1996.

⁴⁵ F.W. Van Oosten *The Doctrine of informed Consent in Medical Law* (1991) 455 (unpublished LLM Thesis) University of South Africa

⁴⁶ In *C v Minister of Correctional Services* 1996 (4) SA 292 (T) it was held that: 'the failure to obtain proper consent to test a person's blood after he or she has voluntarily given a blood sample was held to be a violation of the person's constitutional right to privacy'

Consent legitimizes medical treatment that would otherwise be assault, based on the maxim “*volenti non fit injuria*.”⁴⁷ The South African court examined women’s right to provide informed consent to an abortion in the case of *Christian Lawyers’ Association v National Minister of Health and others*⁴⁸ and held that this right was fundamental to individual self-determination.

An act of medical treatment by a doctor on a patient is not an injustice if the patient is a willing participant and submits to treatment with full knowledge of the risks and all the consequences of such treatment.⁴⁹ Patients may give consent verbally, in writing, or tacitly by conduct.⁵⁰ But it is recommended by the HPCSA that physicians obtain written consent whenever possible, so that in the unlikely event of a malpractice suit, consent can be proven and the provider protected.⁵¹

But written consent is not always given or needed. And there is a legal foundation for another form of consent called “implied consent,” which is distinct from informed consent. Marsh⁵² states that implied consent is present from the moment the patient visits a doctor for advice and help; ‘implicit in this consultation is that confidential information will be given, physical examination performed and treatment given without asking formally for consent.’⁵³

Marsh stated that historically the concept of implied consent was commonly used in gynaecological practice where it was a routine procedure for pregnant women to have blood samples taken for routine testing of congenital syphilis, which is harmful to the embryo and could be easily treated with the administration of penicillin with no prior consent or permission from the patient.⁵⁴

In a study evaluating the quality of informed consent obtained by doctors in their clinical practice, 57 percent of those interviewed confirmed that implied or presumed consent was

⁴⁷ *Stoffberg v Elliot* 1923 CPD 148 and *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710, cited in R. Thomas ‘Where to from *Castell v De Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and standards of disclosure’ (2007) 124 *SALJ* 188 : ‘ a person may commit the iniuria of assault merely by interfering or attempting to interfere with the body of another’

⁴⁸ *Christian Lawyers Association v National Minister of Health and Others* 2004 (4) SA 31 (T).

⁴⁹ *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicae Curaie)* 2005 (1) SA 509 (T).

⁵⁰ Patrick van den Heever *Therapeutic Privilege in South African Medical Law* (unpublished LLM Thesis University of Cape Town, 1997).

⁵¹ Guidelines for Good Practice in the Health Care Professions, *Seeking patient’s Informed Consent: The Ethical Considerations*. Booklet 9 (2008) para13.

⁵² B.T Marsh ‘Informed Consent- help or hindrance?’ (1990) 83 (10) at 603-606 *Journal of the Royal Society of Medicine J R Soc Med*. www.ncbi.nlm.nih.gov/NCBI (accessed 15 May 2015)

⁵³ B.T Marsh ‘Informed Consent- help or hindrance?’ (1990) 83 (10) at 603-606 *Journal of the Royal Society of Medicine J R Soc Med*.

⁵⁴ B.T Marsh op cit 35. at 603

used in emergency situations rather than in ward or clinic situations.⁵⁵ Although a significantly high percentage of gynaecologists implement the practice of informed consent in the ward or clinical situations, the question one must now ask regarding those doctors who are seen to deviate from obtaining the informed consent is: How or from whom do they obtain permission to make important health decision and/or treatment choices for their patients?

Sidin states that: ‘Informed consent is related to patient’s rights in terms of attainment of better health care’⁵⁶ which is of paramount importance to the patient. Although informed consent is required for each specific procedure, health practitioners and health institutions use standard or generic consent forms. Carstens et al contend that this practice must be avoided for the simple reason that ‘obtaining of an informed consent for vasectomy is not comparable to informed consent to be obtained for endoscopic sinus surgery.’⁵⁷

Hoppe and Miola highlighted that a valid conception of consent issues require that it be mandatory, and consider capacity based on English Law. They stress that a valid improved consent requires a combination of all relevant considerations, such as a patients’ capacity to consent, risk disclosure, clarity of intended treatment and the presentation of alternatives.⁵⁸ A law that fails to recognize any of these aspects is an incomplete one, and can fail patients.

In a healthcare setting, one needs to carefully assess what information is disclosed to the patient, whether there is sufficient information supplied to the patient, and whether the patient has the mental and legal capacity to make an informed decision before an intervention.⁵⁹

The court in *Castell v de Greef*⁶⁰ held that in our South African context the doctor’s duty to disclose a material risk is essential in the process of obtaining the patient’s informed consent to the operation and for any other post operative procedures. The court held that informed consent is a requirement for a defence of *volenti non fit injuria* to exclude the wrongfulness of the assault.

⁵⁵ Chima SC ‘Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study’ (2013) 12 <https://www.bmcmedcentral.com/articles/10.1186/1472-6939-14-S1-S3>. (accessed 09-10-2017)

⁵⁶ Sidin A.I ‘The obstacles of valid informed consent’ (2016) 3 (5) *International Invention Journal of medicine and Medical Sciences* 85-88 ISSN: 2408-72460 [http://internationalinventjournals.org/journals/IJMMMS/Archive/2016/May-vol3 issue](http://internationalinventjournals.org/journals/IJMMMS/Archive/2016/May-vol3%20issue) (accessed 09-10-2017).

⁵⁷ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 878.

⁵⁸ Nils Hoppe and Jose Miola *Medical Law and Medical Ethics* (2014).

⁵⁹ Nils Hoppe and Jose Miola *Medical Law and Medical Ethics* (2014) 38.

⁶⁰ *Castell v De Greef* (1994) SA 408 (C) 425

In *Castell*, Ackerman J further stated:

‘I therefore conclude that, in our law, for a patient’s consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

- (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or
- (b) a medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it’⁶¹

Later in the paper, we shall compare the UK, Canadian and British models regarding ‘risk disclosure and informed consent’ and use, negligence and ‘trespass’.⁶² South African courts, unlike British ones, do not apply the Bolam test,⁶³ which suggests that a doctor does not act negligently if he or she adopts a practice of disclosure which satisfies a responsible body of medical opinion, even if other doctors do not adopt this practice.⁶⁴ South African courts favor a model that gives priority to the fundamental rights of autonomy and self-determination, adopting principles from the Australian case of *Rogers v Whittaker*⁶⁵ when adjudicating the standard of care and a person’s right to make independent decisions regarding their own lives.⁶⁶

Lord Scarman, in the United Kingdom case of *Sidaway v Board of Governors of Bethlem Royal Hospital*⁶⁷ stated that:

The Bolam Principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.⁶⁸

⁶¹ *Castell v De Greef* (1994) SA 408 (C) 426

⁶² Nils Hoppe and Jose Miola *Medical Law and Medical Ethics* (2014) 38.

⁶³ *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582.

⁶⁴ Harberfield. L ‘Informed consent and infant male circumcision’ <http://www.cirp.org/library/legal/harberfield> (accessed 21-09-2017)

⁶⁵ *Rogers v Whittaker* (1992) 175 CLR 479 at 487.

⁶⁶ *Ibid.*

⁶⁷ *Sidaway v Board of Governors of Bethlem Royal Hospital* (1985) All ER 643

⁶⁸ *Ibid.*

In the United Kingdom, the roles and duties of gynaecologists (doctors who deal primarily with women's reproductive issues) and obstetricians (doctors who deal women during pregnancy and childbirth) seem to be somewhat artificial in spite of them being sub-specializations.

Doctors of each specialty frequently practice in both disciplines, as there is a high incidence of claims brought on behalf of infants, mostly alleging brain damage, and mothers having substantial claims for maternal injury or by their spouses in the event of the mother's death.⁶⁹

1.4 The relevance of informed consent in the field of gynaecology and obstetrics

This study endorses the need for the proper enforcement of practices, procedures and policies, considering both domestic and international rules, with respect to informed consent within the field of gynaecology and obstetrics. If implemented effectively and with strict measures, these polices can do as intended and reduce incidents of negligence, unlawful assault and other conduct by medical professionals that negatively impacts on a woman's sexual and reproductive self-determination.⁷⁰ They will also protect the patient's rights in terms of the Constitution of the Republic of South Africa,⁷¹ especially that of dignity, and of psychological and bodily integrity, protected by the National Health Act,⁷² the common law⁷³ and in the criminal law.⁷⁴

There is a need for gynaecologists and obstetricians to move away from their paternalistic approaches, in the hope that this will reduce deviation from lawful informed consent and the number of ensuing medical negligence cases being brought against them.⁷⁵ This is especially the case, for example, for a woman undergoing labor or childbirth, or in a similarly distressing situation, and where she may not be able to understand the unfolding of events, especially complicated or unforeseen ones. As a result, they may not be capable of giving proper informed consent to any additional surgical or medical interventions, such as an epidural. Here, a doctor may be faced with legal and ethical challenges such as a woman in

⁶⁹ M.Powers and N.Harris *Clinical Negligence* 2nd ed (1994) 920.

⁷⁰ Section 12 of the Constitution (Act 108 of 1996) provides that: 'Everyone has a right to bodily and psychological integrity, which includes the right:- (a) to make decisions concerning reproduction;(b) to security in and control over their body; and(c) not to be subjected to medical or scientific experiments without their informed consent.'

⁷¹ The Constitution of the Republic of South Africa Act No. 108 of 1996

⁷² The National Health Act 61 of 2003

⁷³ G.A. Ogunbanjo and D. Knapp van Bogaert 'Ethical issues in family practice: Informed consent- Disclosure of information in Clinical Practice' (2004) 46(3) *SA Fam Prac* 35-37 'Common law codifies a conviction that people have a fundamental right to self-determination, namely to control their own lives and bodies.'

⁷⁴ The Criminal law (Sexual offences and related matters) Amendment Act No. 32 of 2007.

⁷⁵ G.Howarth and P.Carstens 'Can private obstetric care be saved in South Africa?' (2014) 7 (2) *SAJBL* 69-73. DOI : 10.7196/SAJBL.319 <http://www.sajbl.org.za/index.php/sajbl/article/> (accessed 21-09-2017)

labor lacking the mental capacity to make an informed decision owing to the fatigue and labor pain she is experiencing, and the doubt cast on the validity of her consent.⁷⁶

A study conducted on the poor quality of informed consent showed that 71 per-cent of physicians surveyed failed to fully explain the risks of complications,⁷⁷ and a study conducted on the trends in malpractice claims for obstetric and gynaecological procedures between 2005 and 2014 showed that the most litigated category of procedure was for operative procedures on the uterus with indemnity claims 27 per cent higher than a combination of all medical specialties.⁷⁸

The nature and scope of gynaecology and obstetrics include the care and treatment of two patients; namely the unborn child as well as the mother. This broadens and multiplies the seriousness and potential harm of violations of patient rights. Demonstrating this, claims for compensation for medical malpractice are usually made against medical practitioners for the following reasons: (a) adverse effects and the inefficacy of oral contraception and intra-uterine devices such as the coil; (b) those arising in surgery, example where the patient is subject to unnecessary operations; sterilizations because of infections; internal injuries sustained during keyhole surgery including to the bowel, bladder and uterus; hemorrhaging and the failure to detect it; and (c) medical issues relating to failure of sterilization or failure to terminate a pregnancy.⁷⁹

Medical practitioners in the field of gynaecology and obstetrics are inconsistent in their approach to informed consent despite their ethical and legal obligations.⁸⁰ Ethical issues may arise in situations where a patient and doctor disagree on a proposed gynaecological or obstetric treatment or intervention.⁸¹ Doctors are obliged to disclose all risks and benefits to their patients and to give them the opportunity to make decisions for themselves and their unborn child provided that they are qualified to give or refuse consent.⁸²

⁷⁶ Elizabeth J. Buechler 'Informed Consent Challenges in Obstetrics' *CRICO/RMF FORUM* September (2007) 19-20 <https://www.rmhf.harvard.edu/~mediafiles> (accessed 19 November 2015)

⁷⁷ Gogos AJ, Clark RB, Bismark MM, Gruen RL, Studdert DM 'When informed consent goes poorly: a descriptive study of medical negligence claims and patient complaints' (2011) September 19; 195 96):340-4 *Med J Aust.* <https://www.ncbi.nlm.nih.gov/pubmed/21929499> (accessed 20-09-2017)

⁷⁸ Glaser LM, Alvi FA, Milad MP ' Trends in Malpractice claims for obstretic and gynaecologic procedure, 2005 through 2014' September (2017) 217 (3) *Am J Obstet Gynaecol* <https://www.ncbi.nlm.nih.gov/pubmed/28549980> (Accessed 06-10-2017)

⁷⁹ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 718-719.

⁸⁰ M.Black 'Vaginal birth comes with risks too- so should it really be the default option?' *The Conversation* (2016) 7 <http://theconversation.com/> (accessed: 21/09/2017).

⁸¹ *Ibid.*

⁸² *Ibid.*

Special attention must be given to women who choose the natural vaginal delivery method of childbirth as they are also at risk of unfavorable outcomes.⁸³ Many women are not fully aware of the possible dysfunction of their pelvic floor, additional risks associated with an episiotomy and possibility of incontinence post-delivery. Although the previously mentioned unique risks of vaginal delivery seem daunting when communicated to an expectant mother it must be balanced with the risks associated with Caesarian section deliveries. Patients very often do not know that the mortality of mother and/or child is significantly higher in Caesarian section deliveries when it is administered as an emergency procedure rather than pre-planned.⁸⁴

The American College of Obstetrician-Gynaecologists (ACOG)⁸⁵ recognizes that obstetricians can face challenges in their treatment of an expectant mother when further treatment is required and consent issues arise. Should the obstetrician believe that a patient's refusal to consent to a certain procedure has an increased likelihood to be to the detriment of her unborn child, the obstetrician can elect to make one of three choices to reach a desirable outcome;

- (1) agree to respect the patient's decision-making;
- (2) decline to participate further and transfer the patient's care to another provider; or
- (3) seek intervention of the courts.⁸⁶

Legally competent patients have the right to refuse health care services.⁸⁷ Patients refusing medical services should therefore not be treated without their consent.⁸⁸ In the British case of, *B v NHS Hospital Trust*,⁸⁹ the patient, who was paralyzed from the neck downward and was sustained by a ventilator, refused treatment.

Initially, two psychiatrists confirmed that she was incompetent to refuse the life-saving treatment. A further assessment from an independent psychiatrist found to the contrary. Despite her refusal to be treated, the physicians ignored the instruction of the patient, as they believed that her prognosis was good and that her condition would improve in a rehabilitation unit. Ms B was awarded damages for technical assault and Justice Butler-Sloss P stated that

⁸³ Ibid.

⁸⁴ A. Dhali, J Gardner, Y Guidozi, G. Howarth, M. Vorster *Deliveries- is there a need for documented consent?* South African Medical Journal (2011) 101:1 SAMJ. at 20-22

⁸⁵ Elizabeth J. Buechler op cit 56.

⁸⁶ ACOG Committee on Ethics: *Ethics in Obstetrics and Gynaecology*, 2nd ed "Patient Choice in the maternal-fetal relationship" Washington DC: The American College of Obstetricians and Gynaecologists (2004).

⁸⁷ J.K. Mason and G.T Laurie *Law and Medical Ethics* (2011) 8th ed.

⁸⁸ J.K. Mason and G.T Laurie *Law and Medical Ethics* (2011) 8th ed.

⁸⁹ *B v NHS Hospital Trust* (2002) 2 [2002] EWHC 429 (Fam)

‘... a competent patient has an absolute right to refuse treatment irrespective of the consequences of her decision,’⁹⁰ and issued very clear guidance to health care professionals as to their responsibility in such cases.

In emergencies where any delay in the provision of the health service might result in a patient’s death or irreversible damage to their health, treatment may be given provided that they have not expressly, implicitly, or by conduct, refused that service.⁹¹

The question remaining is this; apart from a medical emergency, when can gynaecologists and obstetricians justifiably deviate from informed consent without reverting back to their patients, and under what specific circumstances is this permissible?

⁹⁰ *B v NHS Hospital Trust* (2002) 2 [2002] EWHC 429 (Fam)

⁹¹ Section 7 of the National Health Act 61 of 2003.

Chapter 2: Concepts pertinent to the doctrine of informed consent

Informed consent is a specific mandate granted by a patient, with legal capacity to consent, to a healthcare practitioner and legitimizes the treatment process under normal circumstances. The patient, after being consulted by a healthcare practitioner, can choose to voluntarily accept or reject the medical treatment, intervention or procedure based on adequate information supplied by the healthcare professional.⁹² For consent to constitute a justification that excludes medical treatment and consequences, the patient must be adequately informed of the benefits and material risks in a language in which he/she understands. It is imperative that the nature, effects and side effects, and consequences of each medical intervention options are communicated to the patient. Based on the information received, the patient can accept the treatment or exercise his/ her right of refusal of medical services, and in that event is told the risks, implications and consequences of such refusal.⁹³

Informed consent as defined in terms of Subsection 6(1) read with Subsection 7(3) of the National Health Act, 2003 is ‘consent given by a person with legal capacity and who has been informed of:

- ‘his/ her health status (except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to their best interests);
- the range of diagnostic procedures and treatment options generally available;
- the benefits, risks, costs and consequences generally associated with each option; and
- his/her right to accept or refuse health services and the implications, risks, obligations of such refusal.’⁹⁴

Apart from medical emergencies and the legal justification of necessity, all medical treatments, procedures or interventions administered to patients without first obtaining informed consent will constitute an assault and are deemed wrongful.⁹⁵

In non-emergency situations, specific care and treatment plans must be consented to and not a generalized consent to care. Patients will also have the time to reflect on all risks and benefits of the intended treatment and have a right to change their decision if they wish to.

⁹² Ibid.

⁹³ Section 6 of the National Health Act 61 of 2003: *User to have full knowledge*

⁹⁴ Section 6(1) and Section 7(1) of The National Health Act 61 of 2003.

⁹⁵ *Broude v McIntosh* (1998) (3) SA 60; *Castell v De Greef* (1994) SA 408 (C).

Concepts pertinent to the doctrine of informed consent will be discussed to the extent that will illustrate how it holds value to achieve a successful healthcare system, for example if there exists a doctor-patient relationship based on open and clear channels of communication, trust, confidentiality, adherence to strict protocol by medical professionals in medical emergencies including the acknowledgement and implementation of their ethical codes and the law.

The key elements for a consent to be considered valid are :-

- (1) legal capacity of the patient (which is determined by his or her mental or decisional capacity as well as the patient's age),
- (2) voluntariness of the patient to freely consent to or refuse treatment (which consent must be obtained without duress or coercion),
- (3) information given to the patient (ensuring that reasonable steps are taken to communicate information on the nature of the treatment, risks and benefits of the treatment , anticipated outcomes , and consequences of refusing treatment).

2.1 The legal capacity of the patient

The doctor who enters into a contractual relationship with the patient has duty to act and treat the patient according to good medical practice.⁹⁶ Failure of a medical practitioner to respect a patient's right to bodily integrity will face civil or criminal claims for assault brought by the patient and/or a complaint to the HPCSA regarding their illegal and/or unethical conduct.

The patient's age and their mental or decisional capacity must be considered well in advance by the healthcare practitioner, to establish whether or not the patient has the legal capacity to grant or refuse consent to treatment. Consent can be obtained orally or in writing or tacitly by conduct.⁹⁷

The age at which a patient has the legal capacity to exercise his /her rights is determined by legislation. With regard to consent from children in South Africa, Sections 129 of the Children's Act⁹⁸ allows a child older than 12 years old, and who has shown sufficient maturity and mental capacity, to acknowledge and understand the benefits, risks and social

⁹⁶ DJ McQuoid Mason and Mohamed Dada *a-z of Medical Law* (2011)166, "Definition: The doctor- patient relationship refers to a situation where a doctor undertakes to treat a patient, and the patient agrees to be treated by the doctor."

⁹⁷ Patrick van den Heever Therapeutic Privilege in South African Medical Law (unpublished LLM thesis, University of Cape Town (1997) 23.

⁹⁸ Section 129 of the Children's Act 38 of 2005.

implications of the medical service, to consent to his or her “medical treatment”⁹⁹ and with regard to “surgical”¹⁰⁰ operation/s he/ she must duly assisted by his or her parent or guardian. On the other hand a parent’s or a guardian’s consent is required for a child who is younger than 12 years old and also in those circumstances where the child lacks the requisite mental capacity and understanding of the benefits, risks and implications of the procedure.¹⁰¹

Under Section 129(6) of the Children’s Act, consent can be obtained from the Superintendent of the hospital or other appropriate authority figure given the circumstances, absent the parents or guardians, or where (i) the medical services is vital to save the child’s life or to prevent a serious injury or disability; (ii) the urgency for the medical service is so great that it cannot be delayed until informed consent is obtained first.¹⁰²

Section 130(1)(a) of the Children’s Act provides that a child may consent to an HIV tests if it is their “best interest” and the child is older than 12 years. Section 130 (2) stipulates under which circumstances consent can be obtained for the child, who is younger than 12 years of age, and where he or she shows no maturity, nor understands the risks, benefits or social implications of the HIV test.¹⁰³ Under those circumstances, then the parent, guardian or provincial head of social, the head of the child protection institution or the superintendent of the hospital can grant consent. Lastly, the Children’s Court can be approached if getting consent from previously mentioned significant others or authorized personnel is unobtainable.

The question of capacity to consent was clarified by Mojapelo J in the case of *Christian Lawyers Association v Minister of Health and Others*¹⁰⁴ where it was held that:

Valid consent can only be given by someone with intellectual and emotional capacity for the required knowledge, appreciation and consent.....what the Choice Act does not do however is to fix a rigid age.....instead of using age as a measure of control or regulation, the legislature....opted to use capacity to give informed consent as a yardstick.¹⁰⁵

⁹⁹ Section 129(2) of the Children’s Act 38 of 2005.

¹⁰⁰ Section 129 (3) of the Children’s Act 38 of 2005.

¹⁰¹ Section 129(5) of the Children’s Act 2005.

¹⁰² Section 129(6) of the children’s Act 38 of 2005.

¹⁰³ Section 130(1)(a) & Section 130(2)(a)(ii) of the Children’s Act 38 of 2005.

¹⁰⁴ *Christian Lawyers Association v Minister of Health and Others* supra 185 at 15.

¹⁰⁵ Ibid.

Currently in South Africa, The Choice on Termination of Pregnancy Act¹⁰⁶ allows a woman or child of any age permission to give an informed consent to a termination of pregnancy procedure. The Act stipulates that if the female is below the age of 18 years, the attending health care professional must advise her to consult with her parents or another person whom she trusts regarding her decision to terminate the pregnancy; the minor is not obliged to take the advice from the health care professional nor can she be prevented from undergoing the procedure.¹⁰⁷ She must however have the maturity, mental capacity and be able to understand and appreciate the risks, benefits and enormity of such a procedure when giving her informed consent to terminate her pregnancy.

In the case of *Christian Lawyers Association v Minister of Health and Others*¹⁰⁸ it was argued that The Choice on Termination of Pregnancy Act was unconstitutional for reasons that it allowed a person below the age of 18, and therefore insufficiently mature to decide on a matter of life and death for the fetus, and to undergo an abortion without her parents' consent. It was held that the Choice on Termination of Pregnancy Act is constitutional in that termination medical procedures required informed consent, implying that the female child had knowledge and appreciation of the knowledge.¹⁰⁹

The provisions of the Sterilization Act¹¹⁰ on the other hand is seen to be in contrast to the ruling in the Christian Lawyers Association case relating to informed consent as it strictly regulates the reproductive rights of minors stipulating that females under the age of 18 years and minors are not allowed to consent to a sterilization procedure.¹¹¹ Minors who's health will be jeopardized during the pregnancy, can be sterilized on condition that their parent's and/ or guardian's consent was first obtained and secondly, that an independent medical practitioner, after a consultation with the minor, makes a written statement that the sterilization procedure would favor the best interest of the child. Special procedures are required in the case of mentally incompetent minors, in terms of the Sterilization Act.¹¹² The medical superintendent is required to convene a panel of experts to assess the request for the sterilization procedure

¹⁰⁶ Sections 5(1) and 5 (2) of the Choice of Termination of Pregnancy Act 92 of 1996. '...no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.' For the purposes of the Act "woman" means a female of any age.

¹⁰⁷ Section 5(3) of the Choice of Termination of Pregnancy Act 92 of 1996 '... in the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends, before the pregnancy is terminated. Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.'

¹⁰⁸ *Christian Lawyers Association v Minister of health and others* 2005 (1) SA 509 (T).

¹⁰⁹ Ibid.

¹¹⁰ Sterilization Act 44 of 1998.

¹¹¹ Section 2 of the Sterilization Act 44 of 1998.

¹¹² Section 3 of the Sterilization Act 44 of 1998.

and determine whether or not the continued pregnancy or the childbirth will ‘constitute a real or material threat to the minor’s physical health’¹¹³ and wellbeing.¹¹⁴

In emergency situations involving children, where a person with parental responsibility to give the necessary consent is unavailable, then the Superintendent or in his or her duly nominated delegate, can award the consent only for the limited medical treatment or intervention, which is required in such emergency.¹¹⁵

A doctor faced with an emergency situation where the patient is unable to consent, for example, due to unconsciousness, he or she can rely on the concept of ‘therapeutic necessity’ to carry out the emergency medical procedure or treatment.¹¹⁶

2.2 Voluntariness of the patient

Where medical and/or surgical intervention is required and the child concerned unreasonably refuses to give his or her consent, then consent can be obtained from The Minister of Social Development.¹¹⁷ Furthermore, to ensure that the best interest of the child is protected,¹¹⁸ consent for the child’s medical treatment and or operation can be also be sought from the Minister of Social Development in circumstance where a parent or guardian: (i) unreasonably refuses to give consent (ii) lacks the capacity to assist the child or giving consent, (iii) cannot be traced, or (iv) is deceased.¹¹⁹

In the case of a patient who is a young child or a mentally or psychologically incapacitated person, such patient is deemed to have diminished capacity to consent.¹²⁰ Consequently, such a patient cannot willfully submit to medical treatment, neither by tacit or presumed consent, as they do not possess the legal capacity to give a valid informed consent.¹²¹

¹¹³ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 905.

¹¹⁴ Section 3 of the Sterilization Act 44 of 1998.

¹¹⁵ HPCSA Guidelines, *Seeking Patients’ Informed Consent: The Ethical Considerations*, Booklet 9, par 9.5.6 (2008).

¹¹⁶ Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) 919

¹¹⁷ Section 129(8) of the Children’s Act 38 of 2005.

¹¹⁸ DJ McQuoid-Mason ‘Can Children Aged 12 years refuse life saving treatment without consent or assistance from anyone else?’ (2014) 104 SAMJ 466.

¹¹⁹ Section 129(7) of the Children’s Act 38 of 2005.

¹²⁰ MA Dada and DJ McQuoid Mason *Introduction to Medico-Legal Practice* (2001) 9 “ A submission to treatment by a patient does not amount to consent. Where, however, patients who are capable of manifesting their will submit themselves to medical treatment in the full knowledge of the nature thereof, and offer no resistance or make no objection to such treatment, the inference will generally be drawn that they have tacitly consented. This principle cannot be taken too far. Such consent may apply to pre-medication on admission and ordinary nursing care, but should not be extended to serious or irreversible treatment. Tacit or presumed consent will not be inferred in the case of young children or mentally ill or defective persons because they do not have the legal capacity to give informed consent.”

¹²¹ MA Dada and DJ McQuoid Mason *Introduction to Medico-Legal Practice* (2001) 9.

Section 8 of the NHA recognizes the right of patients to exercise their autonomy and self-determination by allowing them to participate in a decision-making process by making choices pertaining to their own health care regime and treatment.¹²² Where a patient is unable to grant the requisite informed consent, a health care provider can provide a service to a patient without obtaining informed consent under the following circumstances as prescribed by the provisions of section 7 of the NHA.¹²³

If consent is to be given by way of substituted consent, then the patient who is capable of understanding must first be consulted even though they lack the capacity to consent.¹²⁴ The National Health Act has made provision for the user of the medical service to participate in the decisions relating to his or her medical treatment.¹²⁵

*VRM v Health Professions Council of South Africa*¹²⁶ dealt with a doctor who was conducting tests on a pregnant woman for HIV and a blood samples were being taken for routine tests where a valid consent was not obtained. The woman was not given the mandatory pre-test HIV counseling nor was she referred to any counseling facilities.¹²⁷ When disputes arose, the doctor claimed to have warned the plaintiff that he was conducting tests for HIV, a claim the plaintiff denied.

The plaintiff had delivered a stillborn baby by Caesarian section. A day later, the doctor informed *VRM* of her HIV status and that the baby had been stillborn due to her HIV status. The enquiry by the HPCSA found that the doctor's conduct had not been improper or disgraceful for failure to provide immediate information regarding the patient's HIV status prior to the delivery and that no further action should be taken against him. However, *VRM* applied to the Pretoria High Court to review that matter, which set aside the decision. The court dismissed the application holding that the consent obtained sufficed for legal purposes, even though it did not qualify as informed consent under HPCSA guidelines. It was held that the difference between consent and informed consent was marginal, and that it was of no real consequence that *VRM* was informed of the outcome of her HIV status at a later stage of her pregnancy.

VRM was granted leave to Appeal to the full bench of the Pretoria High Court on the basis that the court *a quo* had erred by failing to take into consideration the guidelines and

¹²² Section 8 of the National Health Act 61 of 2003.

¹²³ Section 7 of the National Health Act 61 of 2003.

¹²⁴ Section 8(2)(a) of the National Health Act 61 of 2003.

¹²⁵ Section 8(1) of the National Health Act 61 of 2003.

¹²⁶ *VRM v Health Professions Council of South Africa* (2003) JOL 11944 (T).

¹²⁷ *Ibid.*

counseling protocol of the HPCSA, and that the HPCSA is itself bound by statute to address complaints of improper and disgraceful conduct. The Appeal court set aside the previous decision and referred the complaint back to the disciplinary committee of the HPCSA for inquiry to be thoroughly investigated and dealt with.¹²⁸

Similarly, in the case of *C v Minister of Correctional Services*,¹²⁹ it was held that taking a blood sample from a prisoner without following proper informed consent protocol constituted an invasion of privacy. The court held that although the prisoner consented to his blood being removed, he did not consent to it being tested for HIV. The conduct of the prison officers in testing the prisoner's blood for HIV and the lack of pre-and post-test HIV counseling, an important component of informed consent, all amounted to an invasion of privacy.¹³⁰

A situation might arise where a gynaecologist while in the midst of the operation may stumble across another issue which need remedy or rectification but for which there has been no informed consent.¹³¹ It is advisable for the doctor to complete his or her present operation and thereafter, together in consultation with the patient, obtain a new consent in preparation for treatment of the second issue. Traditionally, a paternalistic approach would be for the doctor to impose the medical treatment in serving the best interest and welfare of the patient.¹³² Currently, medical professionals request that the patient gives consent for each and every procedure personally in all circumstances except where the patient is unconscious, drunk, is a minor or mentally incapable.¹³³ If the patient is unable to consent for reasons such as mental incompetence, a 'substituted consent'¹³⁴ should be obtained from a nominated person duly authorized to consent on his or her behalf.¹³⁵ The patient must grant the mandate to the substituted person in writing;¹³⁶ the patient must have the legal capacity to delegate such authority and the substituted person can have authority to grant consent in terms of any law or court order.¹³⁷

¹²⁸ Christa van Wyk 'Pregnancy and HIV in South Africa: Women's rights to be informed' (2007) 70 *Tydskrif HRHR* 584-595.

¹²⁹ *C v Minister of Correctional Services* (1996) 4 SA 292 (T).

¹³⁰ MA Dada and DJ McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) 8-9.

¹³¹ Section 7 (1) (e) of the National Health Act 61 of 2003.

¹³² J.K. Mason and G.T Laurie *Law and medical ethics* (2011) 8th ed.

¹³³ HPCSA Guidelines, *Seeking Patients' Informed Consent: The Ethical Considerations*, Booklet 9, para 13 (2008). S.A Strauss *Doctor, Patient and the Law: A Selection of Practical issues* 3ed (1991) 3.

¹³⁴ Section 7 (1)(a)(i) of the National Health Act 61 of 2003.

¹³⁵ Section 7 (1)(a)(ii) of the National Health Act 61 of 2003.

¹³⁶ Section 7(a)(i) of the National Health Act 61 of 2003.

¹³⁷ Section 7(a)(ii) of the National Health Act 61 of 2003.

In some situations, for example where the patient is in excruciating pain and is unable to fully comprehend the information being delivered by the medical practitioner then he or she can voluntarily waive his or her right to receive medical information regarding the nature, material risks, anticipated outcomes, consequences and alternatives to the proposed treatment. In these circumstances, a substituted consent or proxy consent can be obtained.¹³⁸

Doctors, as well as all other medical professionals, are under an ethical and legal duty to respect their patient's right to privacy, to hold personal information and records of their patients as private and confidential unless there is a legitimate obligation to disclose the patient's information. A patient has an expectation of privacy and their personal information can only be distributed or shared once prior consent is obtained.

The physician is primarily responsible for confirming that proper consent is obtained prior to a medical intervention and cannot rely on other health care providers, like the theatre nurse, to ensure the required consent is correctly on file.¹³⁹ A medical practitioner who conducts a medical procedure without the necessary consent can be held liable and may be found guilty of assault and an invasion of privacy.¹⁴⁰

Obstetricians are known to delegate duties to midwives during labor and in times of delivery.¹⁴¹ Midwives are recognized as independent health care practitioners who are able to make diagnoses, exercise clinical judgments and administer treatments independently from a physician.¹⁴² The burden and onus of ensuring that the qualifications and the requisite skill and diligence of supporting midwives, rests on the obstetrician.¹⁴³ This relationship between theatre sisters and attending surgeons in hospitals was discussed in *Van Wyk v Lewis* and it was concluded that obstetricians and gynaecologists both have an obligation to independently ensure a reasonable standard of treatment for women for whom they have accepted responsibility.¹⁴⁴

¹³⁸ JG Malcom *Treatment choices and Informed Consent: Current Controversies in Psychiatric Malpractice Litigation* (1988).

¹³⁹ Howarth GR. The threat of litigation: Private obstetric care-quo vadis? (2011) 4 (2) *South African Journal of Bioethics and Law* 85-88

¹⁴⁰ Ibid.

¹⁴¹ Ibid.

¹⁴² ibid

¹⁴³ Ibid.

¹⁴⁴ *Van Wyk v Lewis* 1929 AD 458-459 "...sister or nurse in a public hospital to a surgeon operating in that hospital, is not that of master and servant nor is it analogous to such a relationship. The sister or nurse is an independent assistant of the surgeon though under his control in respect of the operation..... She has to prepare the operating theatre to see that the instruments are sterilized and that everything is made ready for the operation. She has her nurses under her and sees that they do what is required of them. She receives her diploma from the state and not by the operating surgeon but by the hospital authorities. The surgeon has no power to appoint her and she receives from him no fees. He has no right to dismiss her. Before and after the operation the doctor has no active control over her. The truth is that hospital sisters and nurses form a distinct branch of the hospital. They are

The theatre sisters and hospital nurses are allied professionals who form a branch of the hospital.

In circumstances where the doctor's own assistants harm or cause injury to a patient, then such doctor will be vicariously liable for any wrongdoing by that assistant on the patient. On the other hand, a doctor who is assisted by a health professional who is employed by a health facility, will be absolved from liability for the wrongdoings of that health personnel purely because he has no control over the health institution's employee. Here, the doctor cannot be held responsible for their wrongful acts or omissions.¹⁴⁵

In recent unreported matter in South Africa, a gynaecologist, Dr. Danie van der Walt, was convicted of culpable homicide in the Witbank Magistrate's Court in September 2016 following the death of a mother at the Life Cosmos Private Hospital and was sentenced to five years imprisonment on the 27th July 2017.¹⁴⁶ Expert evidence produced at the HPCSA hearing as well as in court revealed that the doctor had failed to examine the patient and manage her post-partum haemorrhage. The patient had suffered a third degree perineal tear, which was repaired under anesthetic in the delivery room instead of in theatre under general anesthetic. An investigation report by a Chief gynaecologist, Dr. Mokete Titus, constituted the most vital expert evidence to the hearing and highlighted Van der Walt's "substandard" patient care and a deviation from informed consent. Dr. Danie van der Walt failed to obtain consent for the use of instruments during the baby's delivery, namely: - the vacuum, which was unsuccessfully applied followed by the use of forceps. The report found that the doctor should have been "in-charge" considering the patients' long 14hour labor and the likelihood of excessive bleeding postpartum but instead Dr. van der Walt gave telephonic instructions to the nurses and allowed them to manage his patient. The patient was eventually taken to theatre but she suffered a cardiac arrest and died as a result of the lack of adequate medical care and attention.¹⁴⁷

members of an allied profession and have duties of their own to perform. They are subordinate to the surgeons but they are in no way their servants. The surgeon is not responsible for what the nurse does in the sense that a master is responsible for the acts of his servant."

¹⁴⁵ David McQuoid-Mason 'An introduction to aspects of health law: bioethical principles, human rights and the law' (2008) 6 (1) *South African Journal of Bioethics and Law* at page 9 "Vicarious liability means that another person's wrongful act even though the first person is not at fault. Whether.....acts"

¹⁴⁶ <https://www.iol.co.za/news/SouthAfrica/mpumalanga/> (accessed 14-09-2017).

¹⁴⁷ <http://www.news24.com/SouthAfrica/News> (accessed 14-09-2017).

Patient autonomy and self-determination are of paramount importance in the treatment process, requiring a doctor's respect and regard for a patient's decisive role in making their own medical decisions.¹⁴⁸

Patients are generally overwhelmed with medical information, stress owing to their medical status, and may very often sign consent forms without fully understanding the material risks and its implications.¹⁴⁹ The National Health Act stipulates that a health service may not be provided without the user's consent unless a delay in administration of the service to the user will result in his or her death or cause irreversible damage to their health.¹⁵⁰ In the event where the user expressly refused consent, the healthcare practitioner must respect the wishes of the patient. The patient cannot be treated at all, even in an emergency.¹⁵¹

This principle of self-determination and patient autonomy respects the patient's health decision choices, all-encompassing issues relating to informed consent as well as, the patient's right to privacy in deciding whether or not to join a medical aid scheme or to choose to pay cash for their medical treatment.¹⁵²

In the event of a non-emergency situation, the doctor must refer the patient to an alternate public medical facility together with a referral letter or alternatively, to a colleague who will make the patient aware that the cost of treatment is included in the disclosure requirements for informed consent as per the National Health Act¹⁵³ who is charging fees according to the medical aid scheme rates.¹⁵⁴

¹⁴⁸ Ames Dhai and David McQuoid Mason *Bioethics, Human Rights and Health Law* (2011) 69.

“Paternalism, the belief that the healthcare practitioner should protect or advance the interests of the patient even if contrary to the patient's own immediate desires or freedom of choice, no longer has a place in the health care context, as a result of the Nuremburg Trials, the Universal Declaration of Human Rights and several other codes and guidelines emanating from international bodies such as the World Medical Association, the value of autonomy and self determination have been recognized as paramount.”

¹⁴⁹ G.A. Ogunbanjo and D.Knapp van Bogaert op cit 53 at 37“ Importantly, a doctor must be aware of the mental state of his or her patient as he or she receives information, as this will influence how it is interpreted . Moreover, since moral concepts and norms derive their meaning and force from the social and cultural surroundings in which they are embedded, while the patient retains primacy, the particular values of the patient as part of his or her community should not be dismissed.”

¹⁵⁰ Section 7(1)(e) of the National Health Act 61 of 2003 ‘...any delay in the provision of health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.’

¹⁵¹ HPCSA Guidelines op cit 153

¹⁵² David McQuoid-Mason ‘ Medical ethics and the payment of fees before treatment ’ (2011) 101 (11) *SAMJ* 798-799

¹⁵³ Section 6 (1) and Section 7(1) of The National Health Act 61 of 2003.

¹⁵⁴ David McQuoid-Mason ‘ Medical ethics and the payment of fees before treatment ’ (2011) 101 (11) *SAMJ* 798-799

2.3 Information given to the patient

Doctors are expected to treat their patients fairly and justly.¹⁵⁵ The nature of the relationship between the doctor and patient within obstetrics and gynaecology, is such that in most cases, the patient is generally healthy and needs monitoring during the gestation period, guidance during her pregnancy, assistance during childbirth and post-natal care. But their most crucial role is to step in in the event of complications that could threaten the pregnancy or the health of the mother.

Gynaecologists and obstetricians are required by law to exercise greater skill and care than general physicians and surgeons.¹⁵⁶ The doctrine of informed consent must thus be dealt with in two phases: Firstly, where the doctor provides a comprehensive and detailed discussion of the treatment and risks involved as well as present alternate treatment options in a language and in a manner ensuring that the patient fully understands the nature and severity of risks and chooses to move forward in that knowledge; and secondly, the doctor must obtain a signed consent form from the patient except when such consent is not possible and medical urgency requires decisive action.¹⁵⁷

The provisions of Section 6 (2) of the National Health Act stipulate further that health care providers, in addition to ascertaining the patient's level of understanding of the information being communicate to them in their own language, also need to take into account the patient's level of literacy when obtaining the patient's informed consent.¹⁵⁸

All patients despite their level of literacy, understanding, value system and linguistic group, must be allowed the opportunity to exercise their right to be the master of their own bodies. A gynaecologist should be especially vigilant in obtaining consent from his/her patient prior to a surgical procedure, as they are aware of the test results, the medical investigation and are able to plan and discuss strategies for the treatment, and/or alternative treatments in preparation for the anticipated outcomes.¹⁵⁹

¹⁵⁵ Ibid.

¹⁵⁶ Powers and Harris: *Clinical Negligence* 2nd ed (1994) 920 -974.

¹⁵⁷ Catherine Swee Kian Tay 'Informed Consent in Obstetrics and Gynaecology' (2007) 7:1 *HKJGOM* 43-46.

¹⁵⁸ Section 6 of the National Health Act 61 of 2003: *User to have full knowledge*

¹⁵⁹ Elizabeth J. Buechler op cit 56 at53.

In the case of *Rogers v Whitaker*¹⁶⁰ it was held that before an informed consent can be said to be given by the patient, it must be shown that such patient was given all the information regarding the operation by the provider, warned of the inherent risks in the operation or treatment and that the provider communicated in a manner that the patient will understand it.

An acceptance of the risk occurs when the patient is fully informed of the benefits and risks of the procedure and treatment and makes an informed choice to proceed with the treatment.¹⁶¹

The law relating to the failure to warn a patient was considered in the case of *Chappel v Hart*¹⁶² where the importance of a disclosure of material risks of the operation to the patient in obtaining informed consent was evaluated. The pertinent question raised was: “ what would the patient have done if warned of the risk?”¹⁶³

Mrs Hart’s oesophagus was perforated during surgery and because of the presence of bacteria the quality of her voice was affected. When Mrs Hart expressed concerns about the procedure, Dr Chappel informed her of the benefits of the procedure and warned her of the risk of perforation to the oesophagus but not that it could impair the quality of her voice. The Supreme Court of New South Wales held in favor of Mrs Hart’s and found that the surgeon was liable for failing to warn her of a previously unreported complication of the procedure. Mrs Hart’s case rested on the fact that if warned of the risk of damage to her vocal cords, she would have differed the procedure and sought services from a more experienced surgeon.¹⁶⁴

A doctor cannot merely make recommendations expecting the patient to envisage problems and thereafter formulate question/s, which may arouse concern and doubt. The doctor must be unbiased throughout the process so as to prevent his or her views to influencing the patient’s decision.¹⁶⁵

The judicial recognition of a doctor’s duty to inform, and the doctrine of informed consent in South Africa was noted as far back as 1923 where Watermeyer J in the *Stoffberg v Elliot* case, stating that everybody has absolute rights, which are justified in law. The right embracing the absolute security of the person must be respected. A person has a right to claim damages for

¹⁶⁰ *Rogers v Whitaker* (1992) 175 CLR 479.

¹⁶¹ *ibid*

¹⁶² *Chappel v Hart* (1998) 156 CLR 517

¹⁶³ *ibid*

¹⁶⁴ *ibid*

¹⁶⁵ HPCSA Guidelines, *Seeking Patients’ Informed Consent: The Ethical Considerations*, Booklet 9 (2008) par 7.1.

any bodily interference, restraint or violations he or she had suffered on account of that interference.¹⁶⁶

The medical professionals must acknowledge the importance of managing a patient's expectations. Conflict and legal action against the medical professional can easily arise if for example, a procedure with a low chance of success is not explained, and a patient goes into the procedure expecting success, a poor outcome will be particularly distressing. Chima explains that challenges to informed consent practices amongst doctors in South African public hospitals include language barriers and the lack of interpreters, as well as overburdened workload and time constraints.¹⁶⁷

The case of *Al Hamwi v Johnston*¹⁶⁸ dealt with a decision of an expectant mother who spoke very little English and did not understand the value of undergoing an amniocentesis procedure. Al Hamwi believed that such a procedure would bring harm to her unborn child and chose rather than to take this perceived risk, to go without vital obstetric information. Al Hamwi's decision, based on her limited understanding of the vital medical procedures and to forego the procedure resulted in her giving birth to a child who was disabled. In this matter, the court had to determine what a reasonable disclosure of risks ought to entail, and held that the doctor bears the burden to ensure that a patient fully understands the medical procedure. Justice Simon did submit that doctors should take 'adequate steps' to make the patient understand but higher importance must be placed on the actual imparting of information and the method of communication of the medical procedure.¹⁶⁹ Writers Hoppe and Miola discussed the flaw in the *Al Hamwi* case and argued that this case failed to provide guidance as to what 'reasonable' communication is and it only laid down a legal rule that there is no duty on doctors to ensure that the patient 'understands.'¹⁷⁰

Dr. Elizabeth Buechler¹⁷¹ further relates a case where a lack of understanding, language barrier, a lack of cultural awareness and cultural differences on the part of the healthcare provider, cost an expectant mother her baby's life. The pregnant woman, who was examined by a locum obstetrician for the first time in the labor ward and who showed signs of fetal distress, was advised by the doctor to have a Caesarian section but refused to do so. The baby

¹⁶⁶ P Carstens and D Pearmain: op cit, 59 at 879.

¹⁶⁷ Chima SC 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) 12 <https://www.bmcmedcentral.com/articles/10.1186/1472-6939-14-S1-S3> (accessed 19 November 2015)

¹⁶⁸ *Al Hamwi v Johnston and Another* (2005) EWHC 206.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

¹⁷¹ E.J Buechler Informed Consent Challenges in Obstetrics *CRICO/RMF*(2007) <https://www.rmt.harvard.edu/~/mediafiles> (accessed 19 November 2015)

was stillborn by vaginal delivery two hours later. It was discovered that many contributory factors led to the mother's decision; that she knew very little English; that she was overwhelmed and felt uncomfortable by a new male doctor now treating her, and who had insisted on delivering the baby via Caesarian section. She didn't realize at the time of the examination the value of the caesarian section delivery, owing to her lack of understanding and inability to comprehend serious risks to the baby's birth via the vaginal delivery.¹⁷²

The decision in *Castell v De Greef*¹⁷³ is the landmark ruling regarding the standard of disclosure required for informed consent to a medical intervention. The court in the *Castell* held that a patient ought to be warned of the material risks and further, for consent to be used as a defense, one needs to satisfy the following:

- a. The person consenting must have had knowledge and must have been aware of the nature and the extent of harm or risk;
- b. The person consenting must understand and appreciate the nature and extent of the harm or risk;
- c. The person consenting must have given his/her consent to such harm or risk;
- d. The consent granted must be comprehensive and extends to the entire transaction so as to include the consequences thereof.¹⁷⁴

The South African courts adopted patient autonomy rather than medical paternalism and regarded the lack of consent as assault on the person instead of negligence and the emergence of a reference for using the 'reasonable patient test' as a test for informed consent and not the 'reasonable doctor test'.¹⁷⁵

Ackerman J, in the *Castell* case further held that a medical practitioner has the duty to warn a patient of the material risk of the intended treatment or procedure and stated that:

- a. A reasonable person in the position of the patient, if so warned of a risk, would be likely to attach significance to it, or
- b. The medical practitioner is or should reasonably be aware that the patient, if warned would likely to attach significance to it.¹⁷⁶

The current expectation within the medical fraternity is to treat patients with respect and to prevent them from being at risk of harm during treatment. This stance was adopted after studies revealed a high rate of harm and even death of patients due to inadequate adherence to

¹⁷² Ibid.

¹⁷³ *Castell v De Greef* 1994 (4) SA 408 (C)

¹⁷⁴ *ibid*

¹⁷⁵ P.A Carstens 'Informed consent in South African medical law with reference to legislative developments' (2015) *The South African Medico legal Society*, available at: new.samls.co.za/node/ (accessed 22 November 2015).

¹⁷⁶ *Castell v De Greef* 1994 (4) SA 408 (C)

infection control, record keeping, patient understanding medicine labels, injections and surgical procedures. The World Medical Association Declaration on patient safety addresses these issues by stating that: ‘physicians must go beyond the professional boundaries of health care and co-operate with all relevant parties, including patients, to adopt a proactive systems approach to patient safety.’¹⁷⁷

This obligation placed on the doctor to obtain consent is regulated by law and not by way of practice and procedure of their profession. Once again, the importance of training in communication and or the employment of interpreters, is required to ensure that every effort is made in using their information-sharing and communication skills thereby ensuring that the patient is fully informed of the risks and benefits of their treatment or procedure, especially during process of voluntarily obtaining consent.¹⁷⁸

Virus, bacteria, syndromes, terminal illness, medical emergencies are some of the issues that the medical fraternity deals with on a daily basis. Medical practitioners may see similarities between some patients but ultimately aim to treat each patient based on each individual patient’s needs. They usually repeat treatments and remedies previously proven to be successful on other patients with similar diagnoses and anticipate similar prognoses. A doctor is not compelled to disclose each and every possible outcome or complication of the intended medical treatment, regardless of its likelihood. Some outcomes are so unlikely that a warning is not necessitated. But they are obliged to inform the patient of any material risks that may arise as a result out of the proposed medical intervention or procedure.¹⁷⁹

The HPCSA Guidelines¹⁸⁰ outline the professional responsibilities of a medical practitioner during the consent process which state that the medical practitioner should provide the patient with information including the purpose of the medical and diagnostic investigation, treatment strategies, pain relief and expectations from the procedure or therapies to be administered, including common and serious side effects.¹⁸¹

Any material risks involved in the procedure or treatment must be discussed with the patient.¹⁸² A medical practitioner, who at any stage recognizes that the patient does not

¹⁷⁷ WMA Publications op cit 84

¹⁷⁸ HPCSA Guidelines, *Seeking Patients’ Informed Consent: The Ethical Considerations*, Booklet 9 (2008) par 2.1 and para 3.1.

¹⁷⁹ C. S. K. Tay ‘Informed Consent in Obstetrics and Gynaecology’ HKJGOM 2007; 7(1) 43- 46.

¹⁸⁰ Ibid.

¹⁸¹ HPCSA Guidelines, *Seeking Patients’ Informed Consent: The Ethical Considerations*, Booklet 9 (2008) para 3.1.3.

¹⁸² HPCSA Guidelines, *Seeking Patients’ Informed Consent: The Ethical Considerations*, Booklet 9 (2008) para 3.1.3 and para 3.1.2.2

understand the full nature and consequences of the medical treatment, is obliged to halt the procedure and explain them fully in order to allow the patient to ultimately make a proper informed decision.¹⁸³ Inherent in our diverse cultural society are the challenges of cultural and language differences that medical practitioners must factor in when determining the patient's level of competence as suggested by writers Appelbaum and Grisso,¹⁸⁴ namely:

- a) The ability to communicate choices;
- b) the ability to understand relevant information upon which the choice is made;
- c) the ability to appreciate the situation according to the patient's own values; and
- d) The ability to weigh various values to arrive at a decision.¹⁸⁵

A failure to fully inform a patient of material risks¹⁸⁶ or the withholding of vital information from a patient is a violation of a medical practitioner's legal duty.¹⁸⁷ After a full disclosure of the benefits and material risks of the proposed medical treatment, the patient has an election to also make an informed refusal of the treatment. A patient's right to self-determination and autonomous choices is in the exercise of his or her right of refusal or acceptance of a suggested procedure or treatment and its alternatives. In the event of a refusal, a doctor is still under a duty to fully explain the benefits of the intended procedure or treatment as well as, the possibility that such refusal can lead to the further deterioration of their health status.¹⁸⁸ The patient's final decision must be respected regardless of whether or not others approve.¹⁸⁹ The refusal of treatment or health service should be recorded by the health care provider and if needs be, the patient must be invited and encouraged to seek another professional opinion.¹⁹⁰

The abovementioned communication skill will assist the doctor to ascertain whether or not the communication of information was successful, and to further clarify and correct for a patient's possible unrealistic expectations. Patients may have a different perception of the likely outcomes post-treatment, and generally, in practice a patient will sign a consent form that broadly describes all anticipated areas of surgery, as well as situations of emergency.¹⁹¹

¹⁸³ Ames Dhai and David McQuoid Mason *Bioethics, Human Rights and Health Law* (2011) 70.

¹⁸⁴ PS Appelbaum and T Grisso 'Assessing patient's capabilities to consent to treatment' *N Engl J Med* 319 (11)(1988)

¹⁸⁵ Ibid.

¹⁸⁶ Ames Dhai and McQuoid-Mason op cit 154 at 50

¹⁸⁷ Ibid

¹⁸⁸ David McQuoid-Mason The National Health Act and refusal of consent to health services by children (2006) 96 (6) *SAMJ* 530 - 532

¹⁸⁹ M.A Dada and DJ Mc Quoid-Mason *Introduction to Medico-legal Practice* (2001) 35-36.

¹⁹⁰ Ames Dhai and David McQuoid-Mason op cit 154.

¹⁹¹ Ibid.

The case of *Birch v University College London Hospital NHS Foundation Trust*¹⁹² considered the requirement that doctors extend their scope of disclosure to include reasonable alternatives to the proposed treatment. *Birch's* claim was that her doctor had breached her duty by failing to disclose the option of an MRI as an alternative diagnostic procedure with far less risk of a stroke than the proposed catheter angiography. The court held in favor of the claimant.¹⁹³ The recognition of the value of offering alternative treatment choices to patients demonstrates the doctor's respect for patient autonomy and self-determination in making medical choices for themselves.¹⁹⁴

In the English and Australian legal systems, it has been held that a patient can sue her gynaecologist for negligence where she claims to have received inadequate information by her doctor to make the necessary informed decision.¹⁹⁵

An example would be where the patient suffers a so-called common complication of uterine perforation during dilatation and curettage procedures that entails the scooping of the lining of the uterine walls, as well as serious secondary complications, like bleeding or bowel injury.¹⁹⁶

In our common law, the medical professional is not at liberty to depart materially from the agreed intended medical intervention especially where it is radically different from the procedure explained and consented to by the patient.¹⁹⁷ A deviation from the intended medical procedure can be justified in situations where: (a) it is in accordance with good medical practice; (b) it takes place in good faith; (c) the risks to the patient is not materially increased, and (d) it would be against the patient's medical interest to allow the patient to recover before giving the necessary consent. These situations are prevalent in cases of emergency on the basis of necessity.¹⁹⁸

South African courts differ from English and Australian ones in that they support the need for full disclosure prior to implementation of the medical intervention, recognizing that a deviation from the guidelines in obtaining an informed consent may result in the offending

¹⁹² *Birch v University College London Hospital NHS Foundation Trust* (2008) EWHC 2237(QB).

¹⁹³ *Ibid.*

¹⁹⁴ C. Monaghan 'Does the Doctor know best? A Deconstruction of informed Consent' (2017) 4 (2) *IALS Student Law Review* 25- 30.

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ M A Dada & DJ McQuoid-Mason *Introduction to Medicolegal Practice* (2001)15.

¹⁹⁸ *Ibid.*

health care personnel being found guilty of an assault, battery or negligence as it is a violation of physical integrity.¹⁹⁹

A study conducted to determine whether the quality of informed consent obtained by South African doctors are consistent with standards of practice used locally and internationally revealed that the execution of the statutory regulations and laws were inadequate thereby requiring the implementation of further education in medical law and ethics to improve the quality of informed consent and improved service delivery in South Africa.²⁰⁰ But the National Health Act protects a doctor who obtains his or her patient's informed consent and discloses all the material risks when obtaining it.²⁰¹

In South Africa it is not legally necessary to obtain a written consent or authorization for a normal vaginal delivery.²⁰² Vaginal deliveries, like other methods, have their own risks; risks of dealing with vacuum assisted or forceps deliveries and injury to the infant and /or mother, risks of tearing of the perineum, haemorrhage and incontinence for mothers.²⁰³ Studies in the UK further highlight that 95 percent of women opt for natural vaginal delivery in their first pregnancy but only 75 percent successfully deliver their babies vaginally. However, 21 percent of these women undergo an emergency Caesarian section delivery.

Expectant women should be fully informed of the nature and risks of vaginal deliveries based on the information that statistics confirm that the women experience complications during their vaginal deliveries including tearing and haemorrhaging, where forceps are used to ease delivery, faecal incontinence post-delivery, and serious risks disclosing that some women have also experienced pelvic-prolapse.²⁰⁴

A higher standard of informed consent for vaginal deliveries would be beneficial for both healthcare practitioner as well as the user as it reinforces the relationship of trust, it affords respect to the patient allowing her to be in control of her body without outside influences, and it can help reduce the risk of complication or the need for changes in procedure during the intervention, especially when the patient cannot give renewed consent for the new

¹⁹⁹ S.C. Chima "Because I want to be informed, to be part of the decision- making": Patient's insights on informed consent practices by healthcare professionals in South Africa. [http://www.njcponline.com/article_\(accessed 25/10/2016\)](http://www.njcponline.com/article_(accessed%2025/10/2016))

²⁰⁰ Chima SC 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) 12 <https://www.bmcmedcentral.com/articles/10.1186/1472-6939-14-S1-S3> (accessed 25/10/2016)

²⁰¹ Section 6 of The National Act no.61 of 2003.

²⁰² A. Dhali, J Gardner, Y Guidozzi, G. Howarth, M. Vorster 'Deliveries- is there a need for documented consent?' (2011) 101 (1) *SAMJ* 20 – 22.

²⁰³ M. Black op cit 60

²⁰⁴ Ibid.

procedure.²⁰⁵ A full disclosure reassures the user of risks and benefits and ideally, renders the patient fully aware of the procedures, costs, implication of unforeseen circumstances and suggestions of how to implement other reasonably medical alternatives when unfavorable outcomes arise or are identified during or post-delivery, such as birth defect.²⁰⁶

A pregnant woman who visits the labor facility seeking admission may do so for the first time or not, but each visit requires a disclosure of the full knowledge of the intended procedures and its inherent risks,²⁰⁷ including the relevant information needed to choose between a natural delivery and a Caesarian section.

Gynaecologists must be mindful of the fact that a woman in labor might not be able concentrate nor able to fully comprehend the sequence of events likely to happen during her labor process. During antenatal visits the gynaecologist ought to inform and prepare the expectant mothers of the labor processes. Where an emergency Caesarian section is warranted, the consent is sought during the delivery because the woman has not given her prior informed consent for the Caesarian section delivery or anesthetic procedure or any other related surgical procedures.²⁰⁸

Essentially, informed consent must be routinely used as a means of communication throughout the antenatal process. This is to ensure that the patient is positively equipped to deal with other related problems, such as fetal heart defect, which may arise during the antenatal period and which can only be identified at birth or post-natal.²⁰⁹ Even a seemingly minute piece of information may turn out to be vitally important to the patient and her newborn. Thus the uniform practice of obtaining informed consent for each and every procedure during the childbirth process will ultimately prepare the patient to know and exercise their rights to their advantage.²¹⁰

²⁰⁵ MA Dada & DJ McQuoid-Mason *Introduction Medico-legal Practice* (2001) 37-38.

²⁰⁶ A. Dhai, J Gardner, Y Guidozzi, G. Howarth, M . Vorster op cit 64.

²⁰⁷ Ibid.

²⁰⁸ Cardoso R, Zarin W, Nincic V, Barber SL Gulmezoglu A M, Wilson C, Wilson K, McDonald H, Kenny M, Warren R, Straus S. E, Tricco A.C .*Evaluation reports on medical malpractice policies in obstetrics: a rapid scoping review.* <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5586050> (accessed 09-10-2017). The clinical specialty of obstetrics is under particular scrutiny because it pays amongst the highest amount in litigation settlements of any clinical discipline. Evidence suggests that physicians perceived as being a higher liability risks are likely to practice “defensive” medicine, whereby avoidance of litigation may take precedence over the patient’s best interest in medical decision-making. In obstetrics, this approach could lead to an increase in unnecessary procedures, such unwarranted Caesarian sections, electronic foetal monitoring, epidural analgesia, and fetal scalp blood sampling during labor.

²⁰⁹ Ibid.

²¹⁰ Ibid.

In the recent UK case of *Montgomery v Lanarkshire Health Board*²¹¹ the Supreme Court ruled in favor of the Appellant who sought damages against her obstetrician. Mrs. Montgomery alleged that Dr McLellan failed to disclose the risks of shoulder dystocia, and to obtain a valid informed consent despite her voicing her concerns during the pregnancy about her diabetes and her ability to deliver naturally. The baby was born with cerebral palsy as a result of the ensuing complications. While normally genetic, 6-8 percent of such cases result from oxygen deprivation.²¹² His shoulder got stuck in the birth canal during the delivery and he suffered a lack of oxygen to the brain for a period of twelve minutes. Such a tragic complication could have been wholly avoided if the mother was advised of the material risks. Two grounds of negligence were advanced by the appellant's defence team, firstly being that warned of the risks, the appellant could have chosen the Caesarian section route and prevented the child's injury and secondly that Dr. McLellan had been negligent in failing to perform a caesarian section delivery after receiving the ante-natal results showing abnormalities in cardiotocograph traces.²¹³

The *Montgomery* case changed the law on informed consent in the UK and was a landmark court ruling which deviated from the 'reasonable –doctor' *Bolam* test and instead supported the shared decision-making model. It now obliges the healthcare practitioner to give a full disclosure of information, risks and options to the health user thereby respecting patient autonomy and self-determination in the process of obtaining informed consent.²¹⁴

Piver mentions that in the United States that the most frequently reported litigated cases filed against obstetricians/gynaecologists include foetal distress with brain damaged infants, including the high incidence of death of the fetus when women choose a natural delivery after previously delivering a baby via caesarian section.²¹⁵

In the case of *Lymberry v Jefferies*²¹⁶ a married woman alleged that the medical practitioner was negligent, in failing to inform her that the x-ray treatment she was to receive for fibrosis uteri could destroy her ovaries, which would render her sterile. The court held that the doctor was not negligent as he successfully proved that he explained to the patient that her menstrual periods would cease, that being a middle-aged woman, she must have understood that this

²¹¹ *Montgomery v Lanarkshire Health Board* (2015) UKSC 11.

²¹² *Ibid*

²¹³ *Ibid*.

²¹⁴ *Ibid*.

²¹⁵ Piver JS *Preparing and winning Medical negligence cases: Gynaecology, Medical Negligence cases*, 3rd Ed (April 17, 2009) JUNS Publishing New York

²¹⁶ *Lymberry v Jefferies* 1925 AD 236.

meant that she would not be capable of bearing children after the treatment.²¹⁷ Some women are able to bear children up until menopause and there is little or no justification for a doctor to assume that a middle aged woman will not want to reproduce further nor should they believe that their patients are aware of the consequences of the treatment being administered without it being fully explained to them. This is the very essence of the doctrine of informed consent.

In *Richter v Estate Hammann*²¹⁸ the court held that there was no obligation on the doctor to meticulously inform the patient of each and every possible adverse consequence and complication of the treatment but that all-significant and usual risks should be disclosed. The test should be one of the reasonable-doctor of that particular position faced with the same problem and whether or not the risks involved in the proposed intervention are material risks.²¹⁹

In the case of *Castell v De Greef*,²²⁰ the court shifted away from the “reasonable doctor standard” and applied the “patient-centered,” subjective test in examining the right to the patient’s informed consent, highlighting the issue of doctors failing to fully disclose all material information and the risks to which a reasonable person would attach significance to and led to the finding that informed consent was lacking in this case.

The case dealt with an unsuccessful prophylactic double mastectomy and breast reduction conducted by the doctor to minimize the risk of breast cancer. The court held again, that the doctor was not obliged to meticulously explain to the patient each and every complication that may arise, but only those of material risk inherent in the proposed treatment. A risk was clarified as being ‘... a material risk if, in the circumstances of a particular case: (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.’²²¹

This decision has significant value in affording a woman the opportunity to exercise her constitutional rights to bodily and psychological integrity, most especially, her rights to choices concerning reproduction and sexual health.²²² To enable women to make informed choices and decisions, they need to be educated and informed of basic biology, of the nature,

²¹⁷ Ibid.

²¹⁸ *Richter v Estate Hammann* 1976 (3) SA 226 (C).

²¹⁹ P Carstens and D Pearmain op cit 59 at 140 : “... it was stated the Richter case that a very unusual risk that could not have expected by any stretch of the imagination is remote and not material; in *Lowren’s* case it was held that the likelihood of 2% of the risk occurring is too remote to be material.”

²²⁰ *Castell v De Greef* (1994) SA 408 (C).

²²¹ Ibid.

²²² S 12(2)(a) of the Constitution (Act 108 of 1996).

risks and expected outcomes of medical interventions and the positive value in undertaking medical strategies proposed by the doctor. It is especially pertinent to those pregnant women who are HIV positive, or those HIV positive women who wish to become pregnant, to be informed of vital health information like the risk of mother to child transmission of HIV; the available options to reduce the risk of this transmission using antiretroviral drugs, formula feeding and delivery by caesarian section; that pregnancy and childbirth may negatively impact on her current health status, that the prognosis of a child born with HIV is poor and that their expected lifespan is only two years.²²³

Christa van Wyk²²⁴ discusses that depending on a women's circumstances, a failure to inform a pregnant woman of her HIV status, together with its associated risks and childbirth will 'deprive her of her right to make informed decisions regarding sterilization, contraception, conception, abortion, the use of antiretroviral drugs during childbirth to prevent infection, and breastfeeding.'²²⁵ Informed consent must obtained for the HIV testing and must part of pre-testing counseling.

Coetzee²²⁶ asserts that in the *Castell* case, that Ackerman J strongly rejected the notion that fear on the part of the doctor in believing that a patient will forego medically indicated intervention if informed of the risks involved, justifies withholding that information.²²⁷ As a result doctors could be liable for assault where their failure to obtain informed consent is motivated by such fear. A medical practitioner is obliged to warn about material risks, to be comprehensive in disclosure, not necessarily to all remote or unusual risks, but to all reasonably foreseeable risks throughout the entire treatment.²²⁸

For a patient to have given "informed consent" to a medical treatment, intervention or procedure, the patient must:

- (1) have knowledge of the nature and extent of the harm or risk involved in the procedure

²²³ Christa van Wyk 'Pregnancy and HIV in South Africa: Women's rights to be informed' (2007) 70 *Tydskrif HRHR* 584-595.

²²⁴ *Ibid.*

²²⁵ *Ibid.*

²²⁶ Lodewicus Charl Coetzee 'Medical Therapeutic Privilege' Masters in Law, University of Pretoria, November 2001: in discussing the South African position regarding therapeutic privilege, 129 -130 he cites and discusses *Castell v De Greef* 1994 (4) SA 408 (C) 417J- 418A saying 'Ackerman J strongly (and, it is submitted, correctly) rejected the notion that the doctor's fear, knowledge even, that a patient will forego a medically indicated intervention if informed of the risks involved, could justify withholding information.....it is the duty of the surgeon to refrain from bringing the risk to his patient's attention.'

²²⁷ *Ibid.*

²²⁸ *Castell v De Greef* 1994 (4) SA 408 (C) 428.

- (2) have an appreciation and understanding of the nature of the harm or risk;
- (3) have consented to the harm or assumed risk; and
- (4) have provided a consent that demonstrates comprehension and that extends to the entire treatment, including its consequences.²²⁹

the court adopted the patient- centred approach as in *Castell v de Greef*, where it was argued that the defendant should have explained the likelihood of “claudication occurring as a result of a iliac bi-femoral bypass.”²³⁰ The doctor was found guilty of medical negligence.²³¹

In the case of *Oldwage v Lowrens*, a vascular surgeon performed an operation on the plaintiff, following consultation and complaints of intense pain in his right leg caused by poor blood supply to the leg. An angiogram test revealed that many of the plaintiff’s arteries were occluded. An urgent iliac bi-femoral operation was performed on the plaintiff, who suffered a post-surgical complication of claudication of his left leg and thereafter sued the defendant for medical negligence.²³²

The doctor then decided to take matter on appeal. The Appeal court had to determine whether the doctor had acted as a reasonable vascular surgeon should, if faced with the same circumstances and would have misdiagnosed the patient’s problem as being primarily vascular in nature rather than neuralgic back pain. The Appeal court dealt with two other main issues: (a) that of informed consent for surgical procedure and whether or not the absence of such consent amounted to assault on the patient; and (b) whether or not the doctor’s surgical intervention caused the plaintiff’s claudication in his left leg? The court accepted reasons advanced by experts showing that there was only a two percent chance of “sub clavian steal syndrome”²³³ occurring. The risk to the plaintiff was so negligible that it was not unreasonable for the defendant to have failed to mention it.²³⁴ The court applied the standard of the reasonable doctor faced with a particular problem as adopted in the case of *Richter and Another v Estate Hamman*.²³⁵ The court was guided by the professional

²²⁹ Ibid.

²³⁰ *Oldwage v Lowrens* 2004(1) SA 532 (C) at 532

²³¹ Ibid.

²³² Ibid.

²³³ <https://en.wikipedia.org> “ Sub clavian Steal Syndrome (SSS) also called Sub clavian Steal Phenomenon or Sub clavian Steal Steno-occlusive disease, is a constellation of signs and symptoms that arose from reversed blood flow in the vertebral artery or internal thoracic artery, due to a proximal stenosis narrowing and /or occlusion of the sub clavian artery.” (accessed 25/10/2016)

²³⁴ *Oldwage v Lowrens* supra 246

²³⁵ *Richter v Estate Hamman* supra 234 at 232G-H.

standards of disclosure and medical opinion regarding what a reasonable doctor ought to do, having regard to all the circumstances in a particular case.²³⁶

It was held that the risk to the plaintiff was so negligible that it was not unreasonable or negligent for the defendant to not have discussed it.²³⁷ The court upheld the appeal and held that an absence of informed consent was not proven and that the claudication was not caused by the doctor's surgical intervention.²³⁸

In the case of *McDonald v Wroe*,²³⁹ the court held that a plaintiff who intends to rely on lack of informed consent bears the onus of proving that on a balance of probabilities the medical practitioner was negligent in failing to properly warn the patient of the particular risks of a particular procedure, and that this omission was a direct cause of the patient's damages suffered.²⁴⁰

The facts of the case involved the non-disclosure of the seriousness of the procedure of dental extractions of the plaintiff's wisdom teeth and possible nerve damage as a material risk of the procedure. The plaintiff had suffered a series of repeated infections in the area of her wisdom teeth and the defendant had correctly advised her to remove these wisdom teeth under general anesthesia. After surgery, the plaintiff experienced numbness on the left side of her face, a result of her "inferior alveolar nerve" being permanently damaged.²⁴¹

In *Esterhuizen v Administration Transvaal*²⁴² case where the plaintiff was subject to X-ray treatment without the proper informed consent being obtained, the court held that consent for X-ray treatment, in the belief that it was harmless or ignorant of the material risks it carries, cannot amount to effective consent to undergo the risks and consequent harm. The court further held the doctors and hospital staff were negligent in that they ought to have fully disclosed to the patient the procedure, its risks, possible disfigurement, cosmetic changes and

²³⁶ Ibid.

²³⁷ *Lowrens v Oldwage* (2006) 1 SA 161 (SCA) at 172.

²³⁸ *Lowrens v Oldwage* (2006) 1 All SA 197 (SCA).

²³⁹ *McDonald v Wroe* (2006) 3 All SA 565 (C).

²⁴⁰ *McDonald v Wroe* (2006) 3 All SA 565 (C) at 568 (7) at par 34: "The defendant's wrongful and negligent failure to warn the plaintiff of the risk involved resulted in the plaintiff consenting to the defendant performing the surgery. He performed the surgery correctly without negligence. The experts were unable to fault the manner in which he performed the surgery in any way. The harm, which the plaintiff suffered, is due to a risk inherent in the surgical procedure in question and which can ensue without negligence on the part of the practitioner, be it a general practitioner or a specialist, who performs the procedure. The harm that the plaintiff suffered is harm she might equally probably have suffered in any event if the surgery had been performed by a specialist surgeon. There is, therefore, no direct causal link between the defendant's negligence (in failing to warn the plaintiff of the risk) and occurrence of the harm, unless it is shown that the plaintiff, upon being warned of risk, would not have undergone the procedure at all. That is not the plaintiff's case."

²⁴¹ Ibid.

²⁴² *Esterhuizen v Administration Transvaal* (1957) 3 SA 710 (T).

where the employment of a particular technique may result in severe irradiation of the tissue to the extent that it might cause ‘death of the tissue’ and the risk of amputation. The servants of the defendant had no right to subject the patient to that particular x-ray treatment without her consent.²⁴³

These cases, read in combination, should show the history of jurisprudence surrounding what is deemed to be adequate information to achieve informed consent. Clearly, while a doctor cannot be held responsible for the most unlikely and unforeseeable event, they are responsible for informing the patient of all reasonably likely and relevant possible outcome/s or side effect/s of the suggested intervention/s.

In a recent case of *Pane v MEC Free State*²⁴⁴ the court held that patients have a dual responsibility of proving negligence against the offending doctor or health care practitioner in addition to proving failure to obtain valid informed consent. Mrs. Pane instituted legal action against the MEC for the Department of Health in Free State and initially claimed that the employees of the defendant were negligent by cutting her intestine and removing her womb. Mrs. Pane then amended her particulars of claim to fully outline the stages of her medical procedures leading the stage where her whole uterus was removed and a colostomy bag was inserted. Mrs. Pane denied that she consented to the removal of her whole womb and stated that she only agreed to explorative laparoscopy. She further maintained that the benefits material risks and consequences of the procedures were not explained to her. The doctor testified that Mrs. Pane’s condition was critical; she was taken to the operating theatre and the only available lifesaving option was an abdominal hysterectomy. Seeing that the severity of the condition was discovered when the patient was under anesthetic, the surgeons, acted in the patient’s best interest of the patient and obtained consent was from the hospital’s superintendent to perform the lifesaving procedure.²⁴⁵

The court dismissed the plaintiff’s action on the grounds that she was unable to allege and prove the negligence, which is a requirement for delictual liability, on the offending doctors or medical health professional on a balance of probabilities.²⁴⁶

But these violations of consent or autonomy are not going to be tolerated by an increasingly informed public for much longer. Currently, with the increase in women attaining higher educational qualifications and skills, and where woman are better informed via the media and

²⁴³ Ibid.

²⁴⁴ *Pane v MEC Free State Department of Health* (2016) ZAFSHC99

²⁴⁵ ibid

²⁴⁶ ibid

other sources about health matters there is raised expectation of the quality of medical services and treatment.²⁴⁷ With a full disclosure of the relevant knowledge regarding one's medical treatment and interventions, the patient is in a better position to improve their medical status by making informed choices. When a health care practitioner engages in "truth-telling," communication of his knowledge, advice and guidance, and shows respect for autonomy, self-determination, it reinforces trust in the relationship, minimizes disappointment and more especially, litigation when the medical intervention has an undesirable outcome.²⁴⁸ This 'truth telling' rapport created by morally sound medical practice, allows for freely voiced opinions or concerns in circumstances where the patient has felt short-changed or where their expectations were unmet.²⁴⁹

The medical professional rules of the HPCSA as well as the World Medical Association clearly stipulate that graduating doctors entering the medical arena are bound by an obligation to ensure that their patients' health is treated with paramount importance.²⁵⁰ But this obligation competes against a profit motive.²⁵¹ Their actions 'must be in the best interest of the patients'²⁵² and medical professionals are expected to 'maintain the highest standard of integrity.'²⁵³ This makes it mandatory for doctors to place the health interests of their patients before payment or any other matters or personal gain.

2.4. Emergency medical treatment

In medical emergencies, health practitioners are ethically, statutorily²⁵⁴ and constitutionally²⁵⁵ bound to provide treatment to prevent imminent harm. Where the patient is unable to give consent or has not actively refused treatment in a crisis, then the health care professional can proceed to administer the life-saving treatment without delay.²⁵⁶ Once the critical period of danger has passed, the doctor can refer the patient to a suitable health facility or provider for

²⁴⁷ Ibid.

²⁴⁸ Ames Dhali and David McQuoid- Mason op cit 14 at 70.

²⁴⁹ Catherine Swee Kian Tay op cit 93

²⁵⁰ The World Medical Association Declaration of Geneva (1948) cited in Ames Dhali and David McQuoid-Mason op cit 14 at 17.

²⁵¹ The World Medical Association (WMA) International Code of Medical Ethics www.wma.net/en/40news/20archives/2000/2000_18index.html (accessed 19/11/2015) 'The Clinical Independence of Physicians: The statement declares that physicians should have the right to refuse to participate in any activities which they believe to be unethical and which are being imposed for either administrative reasons or financial gain'.

²⁵² Ibid.

²⁵³ The Health Professions Council of South Africa (HPCSA) Guidelines '*Ethical and Professional rules of the Health Professions Council of South Africa as promulgated in Government Gazette R717/2006* Booklet 2, 27A(c) www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_2_generic_ethical_rules_with_anexures.pdf (accessed 19 November 2015).

²⁵⁴ Section 5 of the National Health Act 61 of 2003.

²⁵⁵ Section 27 (3) of the Constitution, Act 108 of 1996

²⁵⁶ Ames Dhali and David McQuoid- Mason op cit 14 at 75.

further treatment with a covering letter.²⁵⁷ A doctor cannot abandon a patient who cannot pay in advance for treatment without making alternate arrangements for the patient.²⁵⁸ And in the event that there are no qualified medical personnel available, and an emergency arises, any person may offer first aid assistance to stabilize them and ensure that they make it to the hospital to be treated professionally.²⁵⁹

A standout example of disregard for health care and human rights laws in South Africa, is a case that occurred on the 12th March 2015 where a pregnant woman was denied any assistance by nurses from the Alexandra Clinic because she had previously registered for medical treatment at the Edenvale General Hospital. The woman was forced to give birth on the pavement outside Alexandra Clinic despite her plea for emergency medical assistance.²⁶⁰

In terms of section 27 (3) of the Constitution, there is a statutory obligation on the medical practitioner, practicing in a public or private setting, to act positively and administer emergency medical treatment, unless the medical practitioner has sound and compelling reasons to refuse such.²⁶¹

In the matter of *Soobramoney vs Minister of Health (Kwa Zulu Natal)*²⁶² the appellant sought to claim his right to emergency medical treatment under section 27 (3) of the Constitution. The appellant believed that his medical circumstances entitled him to receive renal dialysis treatment at a state hospital. Justice Chaskalson P, analyzed the provisions of section 27 of the Constitution together with the obligations of the state under these provisions and concluded that the appellant's claim must fail on the grounds that section 27 (3) envisages a sudden dramatic event or occurrence which in terms of time, is of a passing nature.²⁶³ The court held that this claim for treatment did not fall under the concept of 'emergency medical treatment' as contained in section 27 (3) instead the claim must be considered in terms of section 27 (1) and section 27 (2) which entitles everyone to have access to health care services provided by the state, all within the 'available resources'.²⁶⁴ He further stated that the concept of 'emergency medical treatment' incorporates the element of suddenness or

²⁵⁷ David McQuoid-Mason op cit 89 at 78.

²⁵⁸ David McQuoid-Mason An introduction to aspects of health law: bioethical principles, human rights and the law (2008) 1 (1) *SAJBL* 7 -10.

²⁵⁹ Ames Dhali and David McQuoid- Mason op cit 14 at 74.

²⁶⁰ S. Siso ' Woman forced to give birth outside clinic' Available at: <http://citizen.co.za/342977/woman-forced-to-give-birth-outside-clinic/> (accessed 2 Nov 2015).

²⁶¹ Section 27(3) of Act 108 of 1996 stipulates that: No one may be refused emergency medical treatment.

²⁶² *Soobramoney v Minister of Health (Kwa Zulu Natal)* (CCT 32/97) (1997) ZACC 17; 1998(1)SA 765 (CC); 1997(12)BCLR 1696 (27 NOVEMBER 1997) Available: <http://www.saflii.org/za/cases/ZACC/1997/17.html> (accessed 15 October 2018)

²⁶³ *ibid*

²⁶⁴ *ibid*

unexpectedness and the right described in section 27 (3) ensures that treatment be given in an emergency or accident or in an unforeseeable catastrophe.²⁶⁵

In July 2015, The KwaZulu-Natal Department of Health investigated the death of a young man, which resulted from the refusal of emergency medical services at two government hospitals.²⁶⁶ It was reported that a critically injured man was refused treatment first by one hospital, and then shockingly, at a second. The patient succumbed to his injuries whilst awaiting emergency medical treatment.²⁶⁷

The report included these comments made by the responding paramedics:

‘... critically injured people are supposed to be transported to the nearest hospital to be stabilized, before being transferred to an alternate hospital. However in most cases the patient is refused any treatment leaving paramedics to either wait on scene for an accepting hospital or drive to the next hospital with the hope of staff assisting.’²⁶⁸

He then went on to say:

‘... far too many poor people are being turned away from government hospitals and are succumbing to their injuries due to hospital staff and doctors finding excuses not to treat dying patients.’²⁶⁹

Sam Mkhwanazi, the spokesperson for the Kwa Zulu-Natal Department of Health re-affirmed the Department’s policy that the patient must be transported to the nearest health facility to be stabilized, irrespective of whether or not it fell into the public or private sector.²⁷⁰ This satisfies the statutory duty in Section 5 of The National Health Act, which provides that: ‘A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.’²⁷¹

Section 7 of the National Health Act provides that consent may be dispensed with, including situations in a medical emergency and where: ‘any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and

²⁶⁵ *ibid*

²⁶⁶ Jeff Wicks ‘Dying man turned away from two hospitals-paramedics’ <http://www.news24.com/southafrica/news/dying-man-turned-away-from-two-hospitals-paramedics-20150713> (accessed 2 Nov 2015).

²⁶⁷ *Ibid.*

²⁶⁸ *Ibid.*

²⁶⁹ *Ibid.*

²⁷⁰ *Ibid.*

²⁷¹ Section 5 of the National Health Act 61 of 2003.

where the user has not expressly, impliedly or by conduct refused that service;²⁷² where the user is unable to give consent and has given a mandate to another person to give consent on their behalf;²⁷³ authorized consent is granted by court order or in terms of any law²⁷⁴ and a failure to treat the user or group of people including the user will result in a serious risk to public health.²⁷⁵

McQuoid-Mason²⁷⁶ discusses section 27(3) of the Constitution as well as section 7 of the National Health Act, asserting that this provision should apply to legally competent patients who have been rendered incompetent to give consent (e.g. because they are unconscious), and require emergency medical treatment.²⁷⁷ An example of this would be where a husband or wife has become unconscious and there is no time to contact the spouse or next-of-kin, as required by the act before beginning the life-saving procedure or intervention to prevent death or irreversible damage to the health of the patient.²⁷⁸

In a medical emergency, once a patient has been assessed and primary life saving procedures have been administered, the doctor is permitted to perform the other secondary procedure/s without the patient's express consent unless it has been refused in advance.²⁷⁹

An example of advanced refusal/s can be found in patients who have been attended to or been treated by the gynaecologist over a period of time during her pregnancy and had during her antenatal consultations authorized and recorded certain treatments she was willing to undergo in the unlikely event of an emergency. In certain situations, should the doctor perform such operation without consent it will constitute an assault on the person and an infringement of the patient's bodily integrity.²⁸⁰ Where the patient has not delegated the duty to consent to anyone nor is he or she able to give consent, then consent can be sought from a spouse or partner, parent, grandparent, major child, brother or sister.²⁸¹

'Therapeutic necessity' is based on the doctrine of implied consent, and is a defense used in instances where a medical professional administers a priority medical intervention in an emergency situation and is then sued for not properly acquiring informed consent.²⁸² A

²⁷² Section 7(e) of the National Health Act 61 of 2003.

²⁷³ Section 7 (b) of the National Health Act 61 of 2003.

²⁷⁴ Section 7(c) of the National Health Act 61 of 2003.

²⁷⁵ Section 7 (d) of the National Health Act 61 of 2003.

²⁷⁶ David McQuoid -Mason and Mahomed Dada: *A-Z of Medical Law* (2011) 94.

²⁷⁷ Section 7 (1)(a)(ii) of the National Health Act 61 of 2003.

²⁷⁸ Ibid.

²⁷⁹ Section 7 (1)(e) of the National Health Act 61 of 2003.

²⁸⁰ Section 7 of the National Health Act 61 of 2003, HPCSA Guidelines, *Seeking Patients' Informed Consent: The Ethical Considerations*, Booklet 9, para 9.4 (2008).

²⁸¹ Section 7 (1)(b) of the National Health Act 61 of 2003.

²⁸² Ibid.

medical practitioner who relies properly on a therapeutic necessity defense argues that they have acted to protect the patient's (or that of another person) legally protected interest, which was already endangered by a threat of harm, and that that onset of that harm had commenced, was imminent and could not be averted in any safe way that also preserved their informed consent.²⁸³

2.5. A closer examination of Informed consent in relation to the termination of pregnancy and forced sterilization.

The Namibian case of *LM and Others v Government of the Republic of Namibia*,²⁸⁴ dealt with informed consent with respect to three HIV positive women who were subject to forced sterilization in the public hospitals in Namibia, in the hope of preventing the infection of newborn children. Here, the court held that a written consent form did not suffice as informed consent. Instead women undergoing a sterilization procedure needed proper counseling in their own language, pitched to a level of their understanding, as well as advancing alternate options to methods of contraception.²⁸⁵ The court case of *LM and Others*²⁸⁶ held that in addition to the knowledge of the nature and effect of the act being consented to, the health care practitioner is required to make notes and document the actual information given to the patient ensuring that the patient was given sufficient information to make an informed decision.²⁸⁷ With regard to a woman's reproductive rights and bodily integrity, the Court also held that obtaining consent during the painful labor process did not promote voluntariness to consent; these women cannot rationally comprehend the consequences of giving consent to the sterilization procedure and their right to autonomous decision-making is diminished.²⁸⁸ The Namibian Government appealed to Supreme Court, which upheld the decision of the High Court.²⁸⁹ The Supreme Court held that the respondent women did not provide sufficient evidence to demonstrate that they were sterilized based on their HIV- positive status.²⁹⁰ After testimony from the three women and two expert witnesses, the court held that the respondents proved that informed consent required for the sterilization procedure was absent.²⁹¹

²⁸³ Ibid.

²⁸⁴ *LM and Others v Government of the Republic of Namibia* 2012 NAHC 211.

²⁸⁵ *LM and Others v Government of the Republic of Namibia* 2012 NAHC 211.

²⁸⁶ Ibid

²⁸⁷ Ibid

²⁸⁸ Ibid

²⁸⁹ *Government of the Republic of Namibia v LM and OTHERS (SA49/ 2012) [2014] NASC 19 (3 November 2014).*

²⁹⁰ Ibid

²⁹¹ Ibid

The court held that health care practitioners have an obligation to obtain consent from the patient:

‘sterilization allows time for informed and considered decisions...health professionals are under an obligation to assess the patient and point out the risks involved in particular procedures so as to enable the patient to make an informed decision and give her consent.’²⁹²

The court further rejected medical paternalism and viewed it as harmful to patients.²⁹³

The South African case of *Isaac v Pandie*,²⁹⁴ highlights a breach of statutory duties by an obstetrician, as well as the need for the patient to reflect on and understand the sterilization procedure for there to be informed consent.²⁹⁵ The court had to establish whether or not the sterilization procedure conducted on the plaintiff was justified by the requisite informed consent. The court found that informed consent was absent and the doctor’s treatment was wrongful because consent satisfying the grounds of justification of the sterilization procedure was not obtained. The plaintiff’s rights to bodily and psychological integrity in terms Section 12 of the Constitution had been violated. It was held further that the forced sterilization violated the patient’s rights to privacy, dignity, reputation and safety.²⁹⁶

In the *Isaacs* case, the plaintiff was admitted to Christiaan Barnard Memorial Hospital in Cape Town where the defendant performed a Caesarian and a sterilization procedure on her. The plaintiff alleged that the defendant did not have her full and informed consent to perform the sterilization procedure and the sterilization constituted an assault.

The plaintiff said that she was ‘guided by the doctor’ at the time to have a Caesarian section and there was no discussions regarding sterilizations at all. Only, during the last three antenatal visits, did the defendant discuss sterilization, and in all pre-natal consultations, the plaintiff had rejected and refused to be sterilized.

The plaintiff maintained that the defendant had performed the sterilization contrary to her consent and express wishes. The defendant was found ‘to have breached his duty of care to the patient; he failed to check the consent form and verify that the patient wanted the sterilization procedure in line with the provisions of Section 4 of the Sterilization Act whereby he failed to inform the patient of the procedure in advance.’²⁹⁷ It was held that the

²⁹² *ibid*

²⁹³ *ibid*

²⁹⁴ *Isaac v Pandie* 2012 ZAWCHC 47.

²⁹⁵ *Ibid.*

²⁹⁶ *Ibid.*

²⁹⁷ Section 4 of the Sterilization Act 44 of 1998 provides: ‘For the purposes of the Act, ‘Consent’ means consent given freely and voluntarily without any inducement and may only be given if the person giving it has: (a) been given a clear explanation and adequate description of the (i) proposed plan of the procedure, and (ii) consequences,

obstetrician acted wrongfully, negligently in breach of his legal and professional duty in performing the sterilization procedure²⁹⁸ and which constituted an assault. The court held further that the defendant's actions were an invasion of the plaintiff's right to privacy, dignity, reputation and safety²⁹⁹ as there was no clinical indication, which warranted the sterilization procedure. Leave to appeal the decision was granted. Mrs. Isaac stated that on admission to hospital she was presented with a pre-drafted consent form based on her doctor's referral for a caesarian section and a sterilization procedure. She refused to sign the consent form; she agreed a caesarian section only and not a sterilization procedure. The court held that both in terms of common law and in terms of the Sterilization Act³⁰⁰ written consent is required for the sterilization procedure. Further, the patient has the right to retract her consent to sterilization anytime prior to the procedure in terms of both common law and Sterilization Act.³⁰¹ It was further held that it was the duty of the nurse to advise the doctor of the patient's retraction of the consent to the procedure; also that it was not a common practice for surgeons to personally inspect the consent forms prior to the medical procedure/s.³⁰²

This finding can be criticized that although medical practitioners are duty bound to obtain consent in both common law and in terms of the Sterilization Act³⁰³, the Act is silent on whom the legal obligation rests for obtaining informed consent however the ethical HPCSA guidelines require that the surgeon is ultimately responsible for obtaining consent.³⁰⁴ The surgeon, when sued, would rely on the defence of *volenti non fit injuria* and it will be difficult to prove all elements of the defence if his delegate obtained the informed consent.

I firmly disagree with the court's approach where it had based its findings on the expert evidence advanced and suggested that it was an accepted practice for the nurse instead of the surgeon who was responsible for obtaining the necessary consent. I firmly believe that the court erred by placing liability on the nurse instead of the surgeon as this approach does not conform with the guidelines as set out by the HPCSA³⁰⁵ which states that there is an express duty on the surgeon to obtain and document the consent before a sterilization procedure and clearly not the obligation of the nurse to ensure that consent is properly obtained.³⁰⁶

risks and the reversible or irreversible nature of the sterilization procedure; (b) been given advice that the consent may be withdrawn any time before the treatment; and (c) understood and signed the prescribed consent form.'

²⁹⁸ *Isaacs v Pandie* supra 197

²⁹⁹ *Isaac v Pandie* supra 197

³⁰⁰ Sterilization Act 44 of 1998

³⁰¹ Sterilization Act 44 of 1998

³⁰² *Pandie v Isaac* (2013) ZAWCHC 123.

³⁰³ Sterilization Act 44 of 1998

³⁰⁴ *HPSCA Guidelines for Good Practice in the Health Care Professions* Booklet 9 May 2008

³⁰⁵ *ibid*

³⁰⁶ *Pandie v Isaac* (2013) ZAWCHC 123.

The court in the case of *Jansen van Vuuren and Another NNO v Kruger*³⁰⁷ dealt with an HIV positive patient's rights to confidentiality and held that the patient has the right to expect that their doctor complies with their ethical and professional guidelines.

The full bench of the Western Cape High Court in the unreported judgment of *Pandie v Isaac*³⁰⁸ heard counsel's argument for the plaintiff which primary focused on the performance of the procedure in the absence of a consent which was negligent in the circumstances and had not focused on the allegations that the performance of the sterilization procedure, without the patient's consent, constituted an assault. The court had to determine whether there was a complete absence of consent and not whether there was an absence of informed consent. Rogers J held that the use of the word "assault" in the medical setting was unnecessary and would lead to confusion.³⁰⁹ Rogers J stated the following in respect to informed consent:

'But the word 'assault' is also misleading where it is used in a medical setting to denote merely that the doctor administered treatment without informed consent, because such conduct, even though it is wrongful, does not without more give rise to liability and would rarely be perpetrated with dolus- it might not even be negligent.'

I am of the opinion that this finding is flawed seeing that the court did not consider dolus-eventualis and it also differs from that of *Jansen van Vuuren and Another NNO v Kruger* in a sense that the court did not find that the surgeon's conduct was wrongful by not complying with the ethical guidelines in personally obtaining the informed consent. HPCSA guidelines regulates that surgeons are duty bound to obtain informed consent.³¹⁰

In the case of *Sibisi NO v Maitin*³¹¹ Mrs Sibisi sued Dr. Maitin for damages suffered by her daughter as a direct result of the negligent conduct of Dr Maitin during the delivery process. The baby's right shoulder suffered nerve injury, resulting in paralysis of the right arm. The High Court dismissed the action and granted leave to appeal to the Supreme Court of Appeal. On Appeal Mrs. Sibisi alleged that informed consent was absent primarily because the doctor had failed to fully disclose the inherent risks of a vaginal delivery given her actual weight and the estimated size of the baby; that he was under a duty to warn her prior to inducing labor of

³⁰⁷ *Jansen van Vuuren and Another NNO V Kruger* (657/91)(1993) ZA SCA 1450; 1993(4) SA 842(AD);(1993) 2All SA 619 (A)

³⁰⁸ *Pandie v Isaac* (2013) ZAWCHC 123.

³⁰⁹ *ibid*

³¹⁰ *HPSCA Guidelines for Good Practice in the Health Care Professions* Booklet 9 May 2008

³¹¹ *Sibisi NO v Maitin* 2014 (6) SA533 (SCA)

the ‘material risks and complications which might flow’ and to offer her alternate options, like a C- section, which she would have chosen as a child birth option, to minimize the risks.³¹² However, Mrs. Sibisi did not advance any argument to convince the court that if she had known of the risks associated with vaginal delivery, she would have opted for C-section.

The court held:

‘ No evidence was lead to show what the reasonable patient in Mrs. Sibisi’s position would have done had she been warned of the risk of shoulder dystocia (a risk that was lower than one percent), and advised about the choice between a vaginal delivery or a C – section. Would she have taken the far greater risk attendant on a C- section or the very minor risk of shoulder dystocia occurring? We do not know.’³¹³

The appeal was dismissed on the grounds that Mrs Sibisi failed to prove that Dr. Maitin was negligent nor his conduct wrongful; that there was no need to establish which standard of disclosure should apply with regard to informed consent matters, thereby failing to extend the common law as enshrined in our Constitution.³¹⁴ The court found that ‘there was no need to develop the common law in order to recognize a patient’s autonomy and right to bodily integrity in making an informed decision as to whether to proceed with one course of action rather than the other’.³¹⁵ It was held that ‘the question of informed consent goes to the wrongfulness element of the Aquilian action’³¹⁶; the negligent conduct on the part of Dr. Maitin will be wrongful if the patient has not given informed consent, however seeing that negligence had not been established, there was no need to consider wrongfulness or grounds excluding wrongfulness.³¹⁷

The HPCSA guidelines clearly state that healthcare practitioners are obliged to discuss the possibilities of problems arising out of the intended procedures and must obtain consent to treat any problems that should arise in the midst of the operation and when the patient is in the state of unconsciousness. This will give the patient an opportunity to consider all available options in advance and then authorize the doctor to proceed to treat additional problems.³¹⁸ If

³¹² *Sibisi NO v Maitin* 2014 (6) SA533 (SCA)

³¹³ *Sibisi NO v Maitin* 2014 (6) SA533 (SCA)

³¹⁴ Chapter 2: Bill of Rights of The Constitution of the Republic of South Africa Act No 108 of 1996.

³¹⁵ *Sibisi NO v Maitin* 2014 (6) SA533 (SCA)

³¹⁶ *ibid*

³¹⁷ *Sibisi NO v Maitin* 2014 (6) SA533 (SCA)

³¹⁸ HPCSA *Guidelines for Good Practice in the Health Care Professions* Booklet 9 (2008) at 3.1.7 ‘Healthcare practitioners should raise with patients the possibility of additional problems emerging during a procedure when the patient is unconscious or otherwise unable to make a decision. They should seek consent to treat any problems which they think may arise and ascertain whether there are any procedures to which the patient would object, or

followed, it would also have prevented a case such as the one just discussed from ever happening.

India presents far more extreme challenges to the ethics of sterilization and informed consent. Studies regarding female sterilization in the Uttar Pradesh State of India indicated an unacceptable and poor quality of care of women³¹⁹ highlight how inadequate procedures relating to informed consent are handled, resulting in morbidity and mortality arising from these appalling conditions under which females are sterilized.³²⁰

This changing healthcare needs of the population as well as the increasing population in India is placing enormous demands on the health system and visits to the Indian sterilization campsites where these women stayed revealed that women were made to sign the consent forms or place their thumb impression on the form without proper consultation and information given to them.³²¹ No explanation of the procedure was given which was a basic requirement of medical practice and as outlined in the Standards Manual³²² issued by the Government of India. The study concluded that the manner in which sterilization camps in Uttar Pradesh were conducted, gave rise to a large number of legal issues, based on a clear violation of the Guidelines as set out in the Standards of Male and Female document³²³ as well as in terms of section 90 of the Indian Penal Code³²⁴ relating to informed consent.³²⁵

2.6. Therapeutic privilege

The concept of therapeutic privilege is a recognized exception to informed consent in modern medical practice.³²⁶ It allows a healthcare practitioner, in exceptional circumstances to use a communication strategy during the consent stage to disclose only what the medical professional deems necessary at that moment³²⁷ and to ultimately protect the patient from the

prefer to give further thought to before they proceed. Health care practitioners must abide by patient's decisions on these issues. If in exceptional circumstances health care practitioners decide, while the patient is unconscious, to treat a condition, which falls, outside the scope of the patient's consent, their decision may be challenged in the courts, or be the subject of a complaint to their employers or the HPSCA. Health care practitioners should therefore seek the views of an experienced colleague, wherever possible, before providing the treatment. They must be prepared to explain and justify their decisions based on such consideration as preservation of life. Health care practitioners must tell the patient what they have done and why, as soon as the patient is sufficiently recovered to understand.'

³¹⁹ A Das, R Rai and D Singh 'Medical Negligence and Rights Violation' *Economic and Political Weekly* (2008) 8 at 3876 – 3879.

³²⁰ *Ibid.*

³²¹ *Ibid.*

³²² Section 1.2.5 as of the Standards for Female and Male Sterilization Act (Gov. of India 1999).

³²³ *Ibid.*

³²⁴ The Indian Penal code Act No. 45 of 1860.

³²⁵ A Das, R Rai and D Singh op cit 204.

³²⁶ Patrick van den Heever 'Pleading the defence of therapeutic privilege' *SAMJ* (2005) 95 (6) pgs. 420 - 421

³²⁷ *Ibid.*

truth.³²⁸ Therapeutic privilege is a paternalistic approach whereby ‘doctor knows best’ comes into play, and the act of withholding of information from the patient places them in a position of authority.³²⁹ The patient should be deemed to be the best person to judge his own interests. The doctor is seen to deliberately lie or omit the full disclosure of information of the intended procedures and its inherent risks with the primary aim being to protect the patient from, for example, possible psychological harmful effects of the normal full disclosure.³³⁰

Therapeutic privilege is an exception to informed consent as seen in the National Health Act.³³¹ In terms of Section 6(1)(a) of the NHA the health care provider is permitted to withhold information from the patient: “in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interest” the patient.³³² The patient must be able to participate in the decision-making process as stipulated in Section 8(1) of the NHA, and any administration of medical treatment without the patient’s consent is considered unlawful or wrongful.³³³ Furthermore the provisions of section 8(3) of the National Health Act stipulates that if the patient is unable to participate in the decision making processes regarding his health and future medical treatment, they should be informed after the administration or provision of the health service unless the disclosure will be contrary to the user’s best interest.³³⁴

The defense of therapeutic privilege is seen as a suitable remedy or ground for justification, by health practitioners who believe that the withholding of vital information from the patient, and the unauthorized administration of medical treatment and/or intervention serves the best interest and welfare of a competent patient.³³⁵ Informed consent on the other hand, empowers the patient to make individual life choices regarding his or her treatment, shows respect for the patient and promotes the patient’s wellbeing.³³⁶

In South Africa the medical practitioner and/or the medical facility can be held liable for assault if consent is absent, irrespective of the success of the procedure or professional skill and care of the attending medical professional. The health care provider cannot deny the user his or her constitutional rights to autonomy and self-determination³³⁷ and the successful

³²⁸ L.C Coetzee *Medical Therapeutic Privilege* (unpublished LLM thesis) University of South Africa (2001) 172.

³²⁹ Pieter Carstens and Debbie Pearmain *Fundamental Principles of South African Medical Law* (2007).

³³⁰ *Ibid.*

³³¹ Section 6(1) and section 8 (3) of the National Health Act 61 of 2003.

³³² Section 6(1)(a) of the National Health Act 61 of 2003.

³³³ Section 8 (1) of the National Health Act 61 of 2003.

³³⁴ Section 8(3) of the National Health Act 61 of 2003.

³³⁵ Section 8 (3) of the National Health Act 61 of 2003.

³³⁶ M.Black op cit 60.

³³⁷ LC Coetzee op cit 277 at 3: ‘Van Oosten 1991a 31, Van Oosten 1995a 67. However, in the case of *Broude v McIntosh* 1998 (3) SA 60 (SCA) the Supreme court of Appeal dealt with the surgeon’s conduct, it was held that it

outcome of the intervention cannot be used as a defense for providing it improperly. On the other hand, a poor outcome of the intervention can be used by the plaintiff to claim damages.

Healthcare providers should be mindful that our legal system has mandatory requirements, to which they are legally bound. The law requires that the patient give their consent freely and voluntarily with full knowledge of the risks, extent of the harm and consequences of the treatment to which they are subjecting themselves. Section 12(2)(b) of the Constitution³³⁸ protects the persons' right of physical bodily integrity as was held in the case of *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk.*³³⁹ This case recognizes that the right encompasses a person's psyche as well as their physical being.³⁴⁰

Some practitioners rely on therapeutic privilege as a defense and justify their conduct by asserting that they anticipate that a full disclosure of information relating to the medical procedure, treatment or operation would have a harmful effect on the patient's emotional and psychological well-being. Doctors claim to use the principle of beneficence by withholding information to ultimately ensure a patient's wellbeing.³⁴¹

In order for a medical practitioner to succeed in a defense of therapeutic privilege, he or she needs to satisfy three elements as suggested by Morton, namely:

1. "the facts and circumstance must justify the use of privilege;
2. the physician must be satisfied that full disclosure will have a significant effect on the patient; and
3. the exercise of the discretion must be reasonable under the circumstances."³⁴²

is a 'bizarre implication of such a notion that, where the risk does not eventuate and the intervention is successful, the doctor's conduct should still be regarded as an assault.'

³³⁸ The Constitution (Act No.108 of 1996).

³³⁹ *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* (1973) 1 SA 769 (A)

³⁴⁰ In *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* (1973) 1 SA 769 (A) '...this court, per Botha JA at 779 held that there was no reason in our law why somebody who, as the result of the negligent act of another, has suffered psychiatric injury with consequent indisposition should not be entitled to compensation, provided the possible consequences of the negligent act would have been foreseen by a reasonable person in the place of the wrongdoer. It was further held that psychological or psychiatric injury is "bodily injury" for the purposes of the predecessor of the legislation now under consideration.'

³⁴¹ Section 6(1) of Act 61 of 2003; <https://medical-dictionary.thefreedictionary.com/Therapeutic+privilege>

Segen's Medical Dictionary© 2012 Fartex Inc. "Therapeutic privilege is an exception to the need for informed consent- not just consent, but properly informed consent- which ostensibly allows a doctor to withhold information from a patient out of concern that full disclosure might psychologically harm the patient and thus imperil the patient's physical health or when full delineation of a procedure's details might cause a patient to forego an operation that the doctor believes is in the patient's best interest or his/her only option for improved quality of life and /or survival."

³⁴² Morton WJ 'The Doctrine of informed consent Medicine and Law' 6 (2) 117- 125 on 121 Medicine and Law

Van Oosten submits that therapeutic privilege gives a physician a unique discretion to forego disclosure, which negates his or her professional duty and legal obligation to disclose information.³⁴³ In such cases the physician must strike a balance between information disclosure, alleviating undue emotional and psychological stress on the patient to enable a desirable outcome, whilst protecting patient autonomy and his/her medical choices.³⁴⁴

In light of the current laws, which promote patient autonomy, self-determination and bodily security,³⁴⁵ there is little room for therapeutic privilege as it undermines the value of informed consent.³⁴⁶ Doctors have chosen to adopt ‘... a more realistic, common sense approach’ in assessing psychological profiles of their patients to establish whether or not a full disclosure of their diagnosis and medical intervention may discourage them from undergoing the proposed treatment.³⁴⁷

In *Tatro v Leuken, Kan*³⁴⁸ non-disclosure of the ‘risk of vesico-vaginal fistula associated with a hysterectomy’ was accepted because the doctor explained that a full disclosure would have resulted in frightening the patient prior to surgery and she ‘might have died or developed serious complications.’ The result would have negatively affected the patient’s emotional wellbeing.³⁴⁹ The court held in favour of therapeutic privilege allowing the physician to withhold information from a patient in circumstances where a complete disclosure of the risks would endanger his or her physical or mental condition.³⁵⁰

In a more recent case of *Teik Huat Tai v Saxon*³⁵¹ the court rejected the obstetrician’s defence of protecting the patient from further depression and found the doctor negligent in failing to advise the patient of the risks of recto-vaginal fistula following a hysterectomy and vaginal damage. The court held that the woman if informed and warned of the risks, she would have not undergone the operation.³⁵²

³⁴³ F. van Oosten *The Doctrine of Informed consent in Medical Law* (1989) 52-53; Also cited by Patrick van den Heever ‘Therapeutic privilege in the South African medical law’ (1993) *De Rebus* July 624 -626.

³⁴⁴ *Ibid.*

³⁴⁵ *Castell v de Greef* supra 236.

³⁴⁶ Patrick van den Heever: ‘Therapeutic privilege in South African Medical Law’, *De rebus*, July 1993, 624.

³⁴⁷ S.A Strauss, *Doctor, Patient and the Law* (1991) 10 cited in Patrick van den Heever, “Therapeutic privilege in South African Medical Law”, *De rebus*, July 1993, 624-626.

³⁴⁸ *Tatro v Leuken, Kan* 512 P 2d 529 (1973).

³⁴⁹ *Ibid.*

³⁵⁰ *Ibid.*

³⁵¹ *Teik Huat Tai v Saxon* (1996) WASC No. 23/95.

³⁵² Harberfield. L ‘Informed consent and infant male circumcision’ <http://www.cirp.org/library/legal/harberfield> (accessed 25-10-2017)

Medical practitioners take a risk and violate the patient's constitutional rights by adopting therapeutic privilege in the treatment process. Apart from the fact that patients are unable to benefit from their right to a full disclosure in making a decision, the patients can, and is likely at some point, to lose trust and faith in their doctors, which will irreparably undermine the doctor-patient relationship.³⁵³ On the other hand, some argue that lying to a patient may be a route to promoting patient autonomy rather than inhibiting it.³⁵⁴ Arguments positively advanced against therapeutic privilege focus on promoting autonomy and self-determination and is based on a physician's legal obligation to obtain informed consent.³⁵⁵

Van den Heever³⁵⁶ discusses therapeutic privilege as a justifiable and 'medically warranted' act of withholding information from their patients to prevent them from becoming so ill and emotionally and psychologically distraught that will cause them to hinder or forego treatment.³⁵⁷

The case of *Canterbury v Spence*³⁵⁸ is an American authority rejecting the idea that medical professionals should withhold information on the basis that disclosure would prevent patients from undergoing treatment or therapy on the basis that this approach is paternalistic and does not afford the patient the benefit of self-determination.³⁵⁹ Justice Robinson CJ stated: 'True consent to what happens to one's life is the informed exercise of choice, and that entails an opportunity to evaluate knowledgeably the options available.'³⁶⁰

The American Medical Association states that 'withholding medical information from patients without their knowledge or consent is ethically unacceptable.'³⁶¹ Physicians should adopt some degree of empathy when communicating medical information to their patients.³⁶² The manner of communication and the timing of imparting medical information by the physician to the patient play a pivotal role in influencing the patient's decision.³⁶³

³⁵³ Patrick van Heever op cit 295.

³⁵⁴ Ibid.

³⁵⁵ Richard G. Fried and Clifford Perlis 'Therapeutic privilege: If, when, and how to lie to patients' (2012) *Dermatoethics* Chapter 10, 33-36.

³⁵⁶ *Canterbury v Spence United States Court of Appeals for the District of Columbia Circuit* (1972) 464: "...it recognized that patients occasionally become so ill or emotionally distraught as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted".

³⁵⁷ Ibid.

³⁵⁸ *Canterbury v Spence United States Court of Appeals for the District of Columbia Circuit* (1972) 464 F 2d 772. Available at: http://lawschool.courtroomview.com/acf_cases/9019-canterbury-v-spence. (accessed 14 November 2015).

³⁵⁹ Ibid.

³⁶⁰ *Canterbury v Spence* 464 F 2d 772 (1972).

³⁶¹ Richard G. Fried and Clifford Perlis op cit 304 at 293.

³⁶² Ibid.

³⁶³ Richard G. Fried op cit.304 at 311

In the case of *Rogers v Whitaker*³⁶⁴ the court held that the ophthalmic surgeon had a duty to disclose to the patient, who was nearly blind at the time of consultation, that there are material risks involved in the proposed operation. In this case, the surgeon advised the patient that an operation to the almost blind left-eye would restore her sight. Unfortunately for the patient, there was no improvement post-operatively and she developed an inflammation in her left eye, which rendered her blind. The patient then sued the ophthalmic surgeon for negligence in failing to fully disclose the material risk of developing sympathetic ophthalmia in her left eye as a result of the operation.³⁶⁵

Coetzee³⁶⁶ further criticizes ‘therapeutic privilege’ stating that the majority of the judges in *Rogers v Whitaker* did not accept the idea of therapeutic privilege as advanced by Molnar. He opines that Molnar favours the use of therapeutic privilege and supports the idea primarily on the belief that if medical practitioners disclose to their patients, all complications and risks attached to an operation, no patient would ever have an operation. Furthermore, under Molnar’s philosophy, where surgery is warranted, a medical practitioner may deliberately withhold information from the patient to avoid anxiety and distress and ensure that they undertake the procedure. Sometimes therapeutic privilege can be used to manipulate patients into granting consent for the benefit of a doctor’s financial gain or in the interest of experiments.³⁶⁷

The results of a study by Lankton *et al*³⁶⁸ on gynaecological patients, testing their emotional responses towards detailed disclosure showed ‘that there was no increased apprehension nor refusal to undergo surgery in those patients who received detailed information.’³⁶⁹

Van den Heever suggests that the doctors must make a clinical assessment of the patient’s psychological state, evaluate the patient’s level of understanding and take cognizance of their reactions to the information conveyed to him or her.³⁷⁰ The doctor using the defence of therapeutic privilege bears the onus of justifying the material non-disclosure.³⁷¹ The courts

³⁶⁴ *Rogers v Whitaker* (1992) 175 CLR 479.

³⁶⁵ *Ibid.*

³⁶⁶ L.C Coetzee op cit 277 at 61 “Molnar, for instance, refers to the argument that if medical practitioner’s were to advise patients of all complications and risks attached to an operation, no patient would ever have any operation. If the patient obviously needs surgery, the author continues, a medical practitioner may deliberately withhold information from the patient to avoid anxiety and distress and to ensure that they undertake the procedure.”

³⁶⁷ *Ibid.*

³⁶⁸ Lankton, Batchelder and Ominsky 1977 “Emotional responses to detailed risk disclosure for anesthesia, a prospective randomized study” *Anesthesiology* 294.

³⁶⁹ *Ibid.*

³⁷⁰ P. van den Heever ‘Pleading the Defence of Therapeutic Privilege’ (2005) 95 *SAMJ* 420-421.

³⁷¹ *Ibid.*

have on occasion accepted a doctor's explanation for adopting non-disclosure as part of the treatment process to reduce the risk of emotional distress and anxiety.³⁷²

The court in the case of *Chappel v Hart*³⁷³ dealt with use of therapeutic privilege to withhold information that would harm rather than benefit the patient. The plaintiff alleged that the surgeon had failed in his duty to disclose material risks and therefore prejudiced her from seeking a second opinion or the opportunity to engage a more senior surgeon.³⁷⁴ The court held the surgeon was required to warn the patient of risks of the medical procedure, further strengthening the jurisprudence respecting patient autonomy and self-determination.³⁷⁵

In the case of *Sidaway v Board of Governors of Bethlehem Royal Hospital and the Maudsley Hospital*,³⁷⁶ a surgeon used a defense of therapeutic privilege when the plaintiff alleged that the he had failed to disclose the risks of the operation. The court held that the surgeon could escape liability for failing to disclose the inherent risks and substantiated his defence of therapeutic privilege by demonstrating to the court that a full disclosure of the risks would have a detrimental impact to the patient's health, including the patient's mental health.³⁷⁷

This case dealt with a man in his thirties who experienced pain in his left eye and was treated by an ophthalmologist. The plaintiff alleged that the failure to inform him regarding the nature of the disease in his eye, together with the results of the histological examinations, and the lack of full explanation of his prognosis, contributed to his medical deterioration into metastasis. This seriously affected the health condition of his right eye, which rendered him unfit to work. The plaintiff claimed material and immaterial damages.³⁷⁸ The court held that the omission to inform a patient of the seriousness of his condition as well as the urgency to obtain further medical examinations constituted a gross violation of medical standards. The court found that the ophthalmologist could not escape liability for the deterioration in the plaintiff's medical condition, as he was directly responsible for not fully disclosing the cancer diagnosis and the consequences that were to follow.³⁷⁹

The ophthalmologist argued that based on his assessment of the plaintiff's psychological instability and his belief that the patient would be unable to cope with the diagnosis, he chose

³⁷² Ibid.

³⁷³ *Chappel v Hart* (1998) 156 ALR 517.

³⁷⁴ Ibid.

³⁷⁵ *Rogers v Whitaker* (1992) 175 CLR 479.

³⁷⁶ *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* (1985) All ER 643 (HL).

³⁷⁷ Ibid.

³⁷⁸ Ibid.

³⁷⁹ Ibid.

not to disclose the results to the patient directly but to rather inform the patient's wife and father.³⁸⁰ The court rejected this argument as being unfounded. The court held that the duty to treat correlates directly with the duty to inform, and thus found no justification in the ophthalmologist's actions placing the responsibility to disclose, to make important urgent medical decisions on behalf of the patient or to encourage the patient to take further tests on the patient's next of kin.³⁸¹

Therapeutic privilege has had few victories in recent years. It is difficult to conceive of common circumstances in which the protection of patient interests could overcome the constitutional duty to informed consent. Perhaps in cases of limited capacity, but the case law has been such that very little room remains in South African medical practice for withholding critical health care information from the patient. In instances where the medical professional believes that the patient will be at risk of psychological harm and anxiety by receiving unfavourable medical information, it is advisable to initially send the patient for a medical assessment and intervention prior to using the therapeutic privilege. Doctors can use the results of the assessment to gauge the patient's level of anxiety, fear, depression and denial of the medical condition. A doctor should be equipped to convey and communicate the patient's diagnosis, risks, remedies, prognosis and will be successful in obtaining informed consent. An active stance towards enforcing proper medical training and communication skills for all medical professionals at tertiary levels will positively benefit the move in the right direction towards attaining informed consent ensuring the reduction of the high incidence of medical negligence cases.³⁸²

³⁸⁰ Ibid.

³⁸¹ BGH 25.4.1989 VI.ZR 175/88 BGHZ 107 222.

³⁸² LC Coetzee op cit 277 at 177-178

CHAPTER 3: A COMPARATIVE ANALYSIS OF INTERNATIONAL AND DOMESTIC LEGISLATION, POLICIES AND PROCEDURES GOVERNING INFORMED CONSENT

The doctrine of informed consent is widely recognized in both national and international legal systems. Informed consent is an important ethical consideration that needs to be view in the context of socio-economical status, the political impact, cultural beliefs, traditions, the quality of life and the extent of wellbeing of individual people in industrialized countries like India, Canada, England, Australia and South Africa comply with informed consent; showing similarities and differences amongst them from their legal practices, customs and traditions. Furthermore, the strategies, accessibility to medical care and implementation of ethical medical practices by health care practitioners will be examined to determine the reasons for the high incidence of medical negligence cases being brought against health care practitioners.

Issues like access to health care services and a patient's inability to pay for the required medical services should not be factors limiting the quality of services received nor should it reduce the value of ethical considerations on the part of the healthcare professional in his or her delivery of the service.

In South Africa for example, the public health care system is underfunded and understaffed and is in contrast with a technologically advanced, well equipped private health care sector, which employs highly trained healthcare professionals and which serves the wealthier members of our population.³⁸³

UK adopts the National Health Services program, which is funded by the government through general taxation and is a free public health care service to all its permanent citizens.³⁸⁴ Their private health system supports the public health care system.

Canada has a universal health care system where the government assists their citizens by paying for their basic health services needed via a government health insurance plan. Additional services that do not fall under the government insurance plan, is paid for by the patient's private health insurance.³⁸⁵

³⁸³ Unicef Health Budget: South Africa 2017/2018 https://www.unicef.org/esaro/UNICEF_South_Africa_--_2017_--_Health_Budget_Brief.pdf (accessed 15 October 2018)

³⁸⁴ Health care in England Available at: https://en.wikipedia.org/wiki/Healthcare_in_England (accessed 15 October 2018)

³⁸⁵ Health care in Canada, Available at : <https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/health-care-card.html> (accessed 15 October 2018)

The Australian government provides free in-patient public hospital care, access to medical services and prescription drugs. Private hospitals are available for elective procedures and are paid for by the patient's private health insurance.³⁸⁶

India offers its citizens free public health care but public hospitals are few and far between; their primary health facilities are poorly equipped and their private medical services are very expensive.³⁸⁷ The private sector is seen to treat the poor unfairly by not allocating enough mandated beds for them and advising the poor patients to pay for medical treatment because the private facilities are unable to provide the necessary health service according to government- mandated rates.³⁸⁸ In February 2018, the Indian Government declared 'The National Health Protection Mission' which will provide public health care/medical insurance coverage to improve the health status of 500 million impoverished families annually.³⁸⁹

3.1 SOUTH AFRICA

Our Constitution and supporting legislation acknowledges that informed consent plays a pivotal role in every South African Citizen which respects and recognizes that these fundamental rights of autonomy and self-determination. We adopt the doctrine of Informed consent as a mechanism to protect individuals from medical procedures, interventions and treatments that require informed consent where it results in risk, harm or disempowerment of the patient and which inevitably violates numerous legal guarantees.

In discussing South African cases, the decision in the leading case of *Castell v de Greef*³⁹⁰ is the precedent used in determining whether or not a valid informed consent³⁹¹ has been obtained from the patient. It was further stated in that case, that the attending medical practitioner must take cognizance, be mindful of any and all material risks³⁹² inherent in the intended planned procedure and to fully disclose to the said patient, such risks. This sets out an expectation under which informed consent is required.

³⁸⁶ The Conversation , Available at : <https://theconversation.com/australias-health-system-is-enviable-but-theres-room-for-improvement-81332> (accessed 15 October 2018)

³⁸⁷ India healthcare: Will the 'world's largest' Public scheme work? Available at : <https://www.bbc.com/news/world-asia-india-42914071> (accessed 15 October 2018)

³⁸⁸ India healthcare: Will the 'world's largest' Public scheme work? Available at: <https://www.bbc.com/news/world-asia-india-42914071> (accessed 15 October 2018)

³⁸⁹ India is introducing free health care –for 500 million people, Available at : <https://www.newsweek.com/india-introducing-free-healthcare-500-million-people-1075607> (accessed 15 October 2018)

³⁹⁰ *Castell v de Greef* supra 236

³⁹¹ Ibid.

³⁹² Ibid.

On the 3rd October 1994, South Africa signed a multilateral treaty called the International Covenant on Civil and Political Rights (ICCPR) and which came into force on the 10th of March 1999. Of importance is Article 7 of the ICCPR is that it prohibits medical and scientific experimentation without explicit informed consent; and Article 9 of the ICCPR, which recognizes the rights to liberty, and security of the person.³⁹³

Under Section 12 (2)(c) of the Constitution, participants identified for a research program must first give their informed consent prior to their participation.³⁹⁴ The National Health Act supplements the provisions of S 12(2)(c) of the Constitution by providing guidelines with regard to obtaining informed consent for experimentation or research on human subjects. The provisions of section 71 of the National Health Act requires a strict adherence to procedure when undertaking experimentation and research of children specifying procedures to be satisfied for both therapeutic and non-therapeutic research and or experimentation in children.³⁹⁵

It is accepted that a doctor could justifiably deviate from the intended treatment in circumstances in which a patient having consented to a specific operation presents with another serious condition that was only discovered in theatre whilst the patient was under general anesthesia; the doctor then deviate from the informed consent obtained on justifiable grounds being:

1. the decision to remedy the new problem is in accordance with good medicine;
2. the remedy is conducted in good faith and will positively enhance the patient's health and well-being by alleviating issues relating to the patient's complaint;
3. that it would not be seen to increase the patient's material risk of harm;
4. in situations when it would not favor the patient's best interest to postpone the operation or procedure for another suitable occasion when a new consent would be in place.³⁹⁶

³⁹³ International Covenant on Civil and Political Rights.

https://en.wikipedia.org/wiki/international_Covenant_on_Civil_and_Political_Rights (accessed 15 May 2015).

³⁹⁴ Section 12 (2)(c) of the Constitution of the Republic of South Africa, 1996.

³⁹⁵ Section 71 (2) of the National Health Act 61 of 2003.

³⁹⁶ Carstens and Pearmain op cit 59 at 911-917.

3.2 INDIA

India, like many other countries, has departed recently, from their traditional paternalistic practice of medicine.³⁹⁷ It has moved instead towards an appreciation of patient autonomy and has put the patient on an equal footing with the doctor in the decision making process.³⁹⁸ They have embraced the concept of informed consent, and this transition has resulted in the creation of workable boundaries, and has moved the doctor-patient relationship in a more contractual direction.

According to Section 13 of the Indian Contract Act,³⁹⁹ consent is seen as a contract whereby: ‘two or more people agree upon the same thing in the same sense.’ Consent must be free of coercion, undue influence, fraud, misinterpretation or mistake and given by a person over the age of 12 years.⁴⁰⁰ Additionally, Section 90 of The Indian Penal Code,⁴⁰¹ indicates that no valid consent can be obtained from a person who is intoxicated, of unsound mind or below the age of 12 years,⁴⁰² as is similarly proscribed in South Africa under Section 129 of the Children’s Act.⁴⁰³

The Indian Statute Book⁴⁰⁴ does not legislate separately for men and women in respect of age limits regarding consent to medical procedures. Medical professionals rely on both Sections 80 and 90 of the Indian Penal Code, thereby applying the law for consent in general terms, all in faith, when obtaining informed consent.⁴⁰⁵ The Indian Contract Act⁴⁰⁶ stipulates that the legal age for parties to validly enter into a contract is 18 years and this should be the threshold for giving valid consent to medical procedures.⁴⁰⁷ Any other law or statute cannot override the Indian Penal Code,⁴⁰⁸ and therefore the legal age for entering into medical contracts provides that the patient has the capacity to give an informed consent.

A judgment in the case of *Samira Kohli v Prabha Manchanda Dr. & ANR*⁴⁰⁹ has laid strict guidelines for obtaining informed consent from patients in India. The patient in this case the patient consented only to diagnostic laparoscopy procedure, but was subjected to a

³⁹⁷ Anil Kohli ‘Medical Consent in India- Ethical and legal issues’ (2007) 8 (2) *Anil Aggrawal’s Internet Journal of Forensic Medicine and Toxicology* available at: www.anilaggrawal.com (accessed 15 May 2015).

³⁹⁸ Ibid.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

⁴⁰¹ Ibid.

⁴⁰² Ibid.

⁴⁰³ Section 129 of the Children’s Act 38 of 2005.

⁴⁰⁴ Anil Kohli op cit 358.

⁴⁰⁵ Ibid.

⁴⁰⁶ The Indian Contract Act of 1872.

⁴⁰⁷ Ibid.

⁴⁰⁸ Ibid.

⁴⁰⁹ *Samira Kohli v Prabha Manchanda Dr. & ANR* 1 (2008) *CPJ* 56 (SC).

hysterectomy and removal of her ovaries under the same general anesthesia, without obtaining necessary consents from the patient. The consent for the hysterectomy was obtained from the patient's mother. The court held the doctor liable for malpractice and stated that despite additional surgery being beneficial to the patient in 'saving time, expenses, pain and suffering are no ground for defence.'⁴¹⁰ Any acts performed in deviation of the authorized consent amounts to assault unless it is a life-threatening situation.⁴¹¹ Clause 13 of the Indian Medical Council Regulations⁴¹² clearly stipulates that the doctor prior to an operation is obliged to obtain their patient's consent.

After a long history of paternalistic practices in India we see that medical professionals have seen the value in adopting the route promoting patient autonomy and self-determination. However, the Supreme Court of India has ruled that the disclosure of information regarding the medical treatment, intervention and prognosis need not be a stringent test as outlined in the Canterbury case⁴¹³ rather to be in accordance with the standards accepted as normal and proper as assessed by a body of skilled professionals in that field. The consent must depend on the patient's physical state, mental state, the diagnosis, the planned intervention and the value attached to the treatment by the patient. Patients must understand what they are consenting to, must have the capacity to consent, must give such consent voluntarily and such consent requires a bare minimum knowledge of the intended procedure. This is "Real consent" and is based on the concept as described by the Bolam test⁴¹⁴ which is currently being used and incorporated into practice having regard to the circumstances and realities in India.⁴¹⁵

3.3 ENGLAND

The laws of England provide that a competent person who has attained 16 years of age may authorise a valid consent to medical examinations, treatment and procedures.⁴¹⁶

The English courts adopted the "Bolam Test" for negligence, which hold doctors liable if they fail to act in accordance with rules, regulations and opinions as prescribed by their Medical

⁴¹⁰ Ibid.

⁴¹¹ D. Singh 'Informed vs. Valid Consent: Legislation and Responsibilities' (2008) 5 (2) Indian Journal of Neuropathy (IJNT).

⁴¹² Indian Medical Council (Professional Conduct, Ethics, & Etiquettes) Regulations -2002.

<http://old.miindia.org/RulesandRegulations/codeofmedicalethicsregulations2002> (accessed 01/06/2015)

⁴¹³ *Canterbury v Spence* supra 307

⁴¹⁴ *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582.

⁴¹⁵ KK Agarwal 'Real consent and not informed consent applicable in India' Indian Journal of Clinical Practice (2014) 25 (4) 392-393 Medilaw, medind.nic.in/iaa/t14/i9/iaat14i9/p392.pdf (accessed 03-05-2018).

⁴¹⁶ C. Tidy 'Consent to treatment in children' Mental capacity and Mental Health Legislation' (2015) Available at: <https://patient.info/doctor> (accessed 14-09-2017).

Council.⁴¹⁷ Currently, the courts in England (and Australia) are using a “reasonable patient” might expect rather than what a “reasonable doctor” might expect a patient to know standard, thereby enforcing stricter standards of risk disclosure for doctors.⁴¹⁸ However, Lord Scarman’s minority view in the *Sidaway*⁴¹⁹ case highlighted the move away from the Bolam⁴²⁰ test in England showing a tendency to adopt a more stringent test of disclosure as outlined in the *Canterbury*⁴²¹ case, regarding a doctor’s duty of disclosure and obtaining informed consent.

Smith v Tunbridge Wells Health Authority,⁴²² in which the surgeon did not mention the risk of impotence following rectal surgery, illustrates that the Bolam⁴²³ test is undergoing a transformation and the courts are rejecting medical opinion found to be unreasonable or irresponsible.

The court in *Pearce v United Bristol Healthcare NHS Trust*⁴²⁴ applied the “reasonable patient standard” and held that a doctor should normally disclose a significant risk that would affect the judgment of a reasonable patient. Lord Woolf further held that such disclosure of the significant risk of the medical procedure allows the patient the ability to determine for him or herself as to what course he or she should adopt thereby allowing such patients greater autonomy and individual rights.⁴²⁵

In the case of *Chester v Afshar*⁴²⁶ the plaintiff suffered from chronic back pain and communicated to her doctor that she wanted to try other options of pain relief with an operation being the last resort. Ms Chester was referred to a neurosurgeon who she alleges pressured her into having the surgery. The neurosurgeon failed to disclose the small but unavoidable risk of paralysis or confinement to a wheelchair, inherent in such a surgery. Further, he failed to offer her alternatives to surgery or to the option of obtaining a second opinion. The plaintiff could not feel sensation, nor could she move her body, post-surgery. A subsequent surgery was performed to determine the cause of the impairment, but could not

⁴¹⁷ *Bolam v Friern Barnet Hospital Management Committee* (1957) 1 WLR 582; (1957) 2 All ER 118 (QBD).

⁴¹⁸ Loane Skene, Richard Smallwood ‘Informed consent: lessons from Australia’ BMJ (2002) Available at: <http://www.ncbi.nlm.gov/pmc/articles/PMC1121943/> (accessed 1st June 2015).

⁴¹⁹ *Sidaway v Board of Governors of Bethlem Royal Hospital* (1984) 1 All ER 1018

⁴²⁰ *Bolam v Friern Barnet Hospital Management Committee* (1957) 1 WLR 582; (1957) 2 All ER 118 (QBD).

⁴²¹ *Canterbury v Spence* supra 305

⁴²² *Smith v Tunbridge Wells Health Authority* (1994) 5 Med L.R.334.

⁴²³ *Bolam v Friern Barnet Hospital Management Committee* (1957) 1 WLR 582; (1957) 2 All ER 118 (QBD).

⁴²⁴ *Pearce v United Bristol Healthcare NHS Trust* (1998) E and WCA 2243 (20th May 1998).

⁴²⁵ *Ibid.*

⁴²⁶ *Chester v Afshar* (2002) 3 All ER 552 at 572.

rectify the paralysis. The court favoured the importance of patient autonomy and held that the plaintiff had suffered a wrong as a result of the defendant's non-disclosure of the material risks of the operation. A full disclosure of the risks would have granted her the opportunity to seek further opinions on her medical condition or choose to postpone the operation for a future date.⁴²⁷

The General Medical Council in the United Kingdom has given the guidelines with respect to obtaining informed consent from patients undergoing medical procedures, including screening or diagnostic tests. A full disclosure of the purpose, the type of testing and its intent should be made available to the patient, as well as the probable and possible consequences of the intervention, and a plan of action once results are received, including how counselling, treatment and post-surgical support is to be given to the patient.⁴²⁸

The legal expectations surrounding informed consent in England are similar to those of international and national countries and one can see that a basic ethical code is adhered to and where professionals are mindful of patient autonomy, self determination, ensuring good medical practice is adhered to by protecting patients from being coerced into medical, treatments, intervention or research void of their consent.

3.4 AUSTRALIA

The consent laws in Australia are similar to those of South Africa, England, Canada and India where competent adults can in common law consent to or refuse medical treatment. Where consent is seen to be absent there may be legal consequences for the health professional concerned as no one may be subject to a medical procedure without consent or lawful justification.

In the Australian case of *Rogers v Whitaker*⁴²⁹ the attending ophthalmologist, despite an enquiry by the patient of any possible danger to his 'good-eye,' failed to disclose to his patient the remote risk of "symptomatic ophthalmia," a rare but serious complication of eye surgery.⁴³⁰ The court found against the ophthalmologist and held that it was an important part of the doctor's duty to disclose "material risks" such as the "possibility of symptomatic

⁴²⁷ Ibid.

⁴²⁸ GR Howarth, P Mulder, B. Jeffery 'Consent for early routine obstetric ultrasound' South African Society for ultrasound in obstetrics and gynaecology, SASUOG, available at: <http://sasuo.org.za/consentforear.asp>. (accessed 14 November 2015).

⁴²⁹ *Rogers v Whitaker* supra 45

⁴³⁰ Ibid.

ophthalmia,” which unfortunately for the patient rendered him blind.⁴³¹ The court went further and stated that:

‘A risk is material, if in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would likely to attach significance to it or if the medical practitioner is, or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.’⁴³²

Further, risks whether or not they are considered life threatening must preferably be described objectively in terms of percentages rather than by subjective terminology. Patients are then able to relate the value of the risk to their health status and their healing process.

In the case of *F v R*⁴³³ a woman was advised by her gynaecologist to undergo a tubal ligation instead of a sterilization procedure to prevent further unwanted pregnancies. The procedure to diminish the reproductive capacity proved to be unsuccessful; a process of recanalization occurred and the woman fell pregnant. The woman sued her gynaecologist for breach of ‘the doctor’s duty to care’ and alleged that the doctor had not fully disclosed the risks to her, despite the procedure holding a failure rate of less than one percent.⁴³⁴

The court did not apply the *Bolam* principle⁴³⁵ and held that the risk of failure of the tubal ligation operation was so low that a careful reasonable doctor would not have advised the patient of “the statistically low failure rate in the absence of a question from the patient.”⁴³⁶

The case of *Battersby V Tottman and The State of South Australia*⁴³⁷ dealt with the issue of whether or not a full disclosure would be of value to a patient who is emotionally and mentally unstable. The patient was considered to be highly depressed and suicidal. A full disclosure would have been presumed to have had detrimental impact on the patient, if she refused the treatment, as she was considered to be a favourable candidate for long-term treatment at a mental institution. The court held in favour of the doctor’s clinical judgment to withhold vital information from patient. Clearly, Dr Tottman believed that the patient’s self-determination and autonomy was diminished and such a decision was justified under the circumstances. Withholding of vital information must be clinically proven to be in the best

⁴³¹ Ibid.

⁴³² Ibid.

⁴³³ *F v R* (1983) 33 SASR.

⁴³⁴ Ibid.

⁴³⁵ *Sidaway v Board of Governors of Bethlem Royal Hospital* (1984) 1 All ER 1018

⁴³⁶ *F v R* supra 389

⁴³⁷ *Battersby v Tottman and The State of South Australia* (1985) 37 SASR 524.

interest of the patient as it violates the legal and ethical doctrine of informed consent.⁴³⁸ Here, the doctrine of informed consent would have failed because the patient was unable to understand nor comprehend the value of the medical information.

Skene and Smallwood,⁴³⁹ contended that despite the fact that Australian doctors had specific protocols regarding their legal duty to inform, which was formulated and produced by the Australian National Health and Medical Research Council in 1993, and despite the widely publicized case of *Rogers v Whitaker*⁴⁴⁰, a survey conducted in 1995 revealed a divergence between medical law and practice. The results suggested that the divergence was a consequence of the fact that medical professionals did not fully understanding their legal obligations regarding their duty to disclose.⁴⁴¹

Skene and Smallwood⁴⁴² further discussed the findings of the High Court of Australia regarding factors that are important in deciding whether a risk from a procedure is material and must be disclosed to the patient:

1. ' more likely and more serious harmful results must be disclosed.
2. Complex interventions require more information, especially when being carried out in an apparently healthy person.
3. When the patient desires for more information.
4. When the risk involved is more important to the patient because of the medical condition or occupation.⁴⁴³

It is clear from the above discussion that the health professional is under a duty of care to provide such information as is necessary for the patient to give consent to the treatment, including all the material risks of the intended treatment and a failure to do so by the health professional may lead to civil liability for an adverse consequence of the procedure.⁴⁴⁴

⁴³⁸ Ibid.

⁴³⁹ L. Skene and R. Smallwood Informed Consent: Lessons from Australia BMJ (2002) 1 Available at : <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1121943>(accessed 01/06/2015).

⁴⁴⁰ *Rogers v Whittaker* (1992) 175 CLR

⁴⁴¹ L. Skene and R. Smallwood Informed Consent: Lessons from Australia BMJ (2002) 1 Available at : <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1121943>(accessed 01/06/2015)

⁴⁴² *ibid*

⁴⁴³ *ibid*

⁴⁴⁴ *Rogers v Whittaker* (1992) 175 CLR

3.5 CANADA

The ethical code of conduct and legislation surrounding informed consent in Canada hold the same value as in South Africa and is based on the principles that everyone who has attained maturity, is of sound mind and who has voluntarily granted a valid consent may be subject to and participate in treatments, operations, research and diagnostic procedures that involves bodily interference.

There is ‘an appalling maternal mortality statistic of Sub-Saharan Africa and the practice of female genital mutilation are rights issues’ and very prevalent.⁴⁴⁵ Female genital mutilation has become a global concern as this practice is seen to have spread over the western, eastern and northeast regions of Africa.⁴⁴⁶ Thus far over ‘100-140 millions women and girls have been subject to this harmful practice which denies these females full enjoyment of their personal, physical, psychological integrity, rights and liberties’.⁴⁴⁷

Female genital mutilation is a cultural practice that is finding its way into our country via migrants from Sudan and other parts of Africa.⁴⁴⁸ Our South African Constitution recognizes the existence of cultural institutions⁴⁴⁹ and affords its citizens a right to culture⁴⁵⁰ which must be compliant with the Bill of Rights.

South Africa has further enacted subsidiary laws to address and criminalize female genital mutilation; specifically section 12(2) of the Children’s Act 38 of 2005 explicitly prohibits genital mutilation of female children.⁴⁵¹

Canadian gynaecologists and obstetricians also face requests for female genital mutilation procedures in a clinical setting from those minority communities who still practice such, for safety reasons. Other shortcomings experienced in the Canadian health sector are issues relating to domestic violence against women, a shortage of maternal health care workers,

⁴⁴⁵ Dorothy Shaw Understanding the relevance of sexual and reproductive rights to professional responsibilities. (2004) JOGC 1095 available at: www.researchgate.net/publication/8035317 (accessed 15 May 2015)

⁴⁴⁶ Asresash D. Abatham, Abdi A. Gele, Johanne Sundby Attitude towards the Practice of Female cutting among school Boys and Girls in Somali and Harari regions Eastern Ethiopia, Available at: <https://www.hindawi.com/journals/ogi/2017/1567368/> (accessed 15-10-2018)

⁴⁴⁷ G.I. Serour ‘Medicalization of Female genital mutilation/cutting’ (2013) 19 (3) *African Journal of Urology* Available at: <http://www.sciencedirect.com/science/> (accessed on 08-10-2017).

⁴⁴⁸ Barbara Kutui, Africalaw ‘Advancing the rule and role of law in Africa’ Available at : <https://africlaw.com/2012/06/07/female-genital-mutilation-in-south-africa/> (accessed 15/10/2018)

⁴⁴⁹ Section 211 of Act No. 108 of 1996

⁴⁵⁰ Section 30 and section 31 of Act No. 108 of 1996

⁴⁵¹ Section 12(2) of the Children’s Act 38 of 2005

access to cervical cancer screening and noteworthy to mention, that although abortion is legalized in Canada, it is not available throughout Canada's health care facilities.⁴⁵²

The Canadian courts favour the 'reasonably prudent patient test'⁴⁵³ in assessing a doctor's standard of disclosure in obtaining informed consent from his or her patient. This test primarily assesses whether a patient informed of such risk will attach value to the risk and further whether the attending doctor aware of such risk to the patient, will share this information believing that the patient will attach value to the disclosure of the risk being communicated.

In a leading case of *Reibl v Huges*,⁴⁵⁴ the Canadian court rejected the paternalistic approach to treatment and emphasized the need for a full disclosure of medical information to patients and leaves no room for a deviation from informed consent by the healthcare professionals. Mr. Reibl, the appellant, consented to a surgery to remove an occlusion in his left internal carotid artery. Although the surgery was conducted properly, Reibl suffered a massive stroke, which left him paralysed on the right side of his body and impotent. Dr Huges encouraged Reibl to undergo the elective surgery rather than as an emergency surgery. Based on the doctor's advice, Reibl consented to the surgery, confidently believing the surgery would remedy his headaches and help him to perform better at work.

The court held that the respondent did not sufficiently inform the appellant of all potential material risks, specifically paralysis and death. All material risks, even if the risks are small or remote, should have been discussed. A full disclosure of medical information by the respondent would have allowed the appellant to reconsider the surgery after assessing his reasonable concerns and might have elected to postpone the surgery for a date in the future.⁴⁵⁵

The case of *Hopp v Lepp*⁴⁵⁶ further obliges a surgeon to fully inform the patient of all material risks, he or she should answer any questions regarding the risks of the procedure posed to him or her by the patient and further, without being questioned, to impart information regarding

⁴⁵² G.I. Serour 'Medicalization of Female genital mutilation/cutting' (2013) 19 (3) *African Journal of Urology* Available at: <http://www.sciencedirect.com/science/> (accessed on 08-10-2017).

⁴⁵³ *Canterbury v Spence* supra 306

⁴⁵⁴ *Reibl v Huges* (1980) 2 SCR 880

⁴⁵⁵ *Reibl v Huges* (1980) 2 SCR 880 where Justice Cory stated: "...the test enunciated relies on a combination of objective and subjective factors in order to determine whether the failure to disclose actually caused the harm of which the plaintiff complains. It requires that the court consider what the reasonable patient in the circumstances of the plaintiff would have done if faced with the same situation. The trier of fact must take into considerations affecting any 'particular concerns' of the patient and any 'special considerations affecting the particular patient' in determining whether the patient would have refused treatment if given all the information about the possible risks."

⁴⁵⁶ *Hopp v Lepp* (1980) 2 SCR 192.

the gravity of the procedure as well as any special or unusual risks that may result from the proposed intervention.⁴⁵⁷

In the case of *Pittman Estate v Bain*,⁴⁵⁸ the Canadian court found that “the use of therapeutic privilege was unwarranted” where the doctor failed to disclose to the patient and his wife that he had contracted HIV from a blood transfusion. Here, the doctor submitted that his choice to withhold the truth about the patient’s HIV status was on account of the patient’s ongoing depression.

The Canadian case of *Adan v Davis*⁴⁵⁹ dealt with cultural issues and informed consent where a 28 year old refugee from Somalia who consulted a doctor for a gynaecological infection that required a drainage procedure but was instead negligently sterilized. The patient who did not speak any English, was assisted by a friend who acted as her interpreter during the consultation, believed that the procedure was supposed remedy her infection.⁴⁶⁰

The General Division of the Ontario Court of Justice held that informed consent rested on two important aspects, firstly, the patient’s ability to understand the information delivered by doctor and the patient’s ability to communicate with the doctor based on the understanding; secondly, that the duty to disclose must extend further than those patients who from the doctor’s same cultural background and who hold the same cultural beliefs. Further, to provide information that would be relevant to the patient’s decision, to fully inform the patient taking into consideration the patient’s cultural beliefs and expectations of patients who, in the similar circumstance would choose to know before submitting to a surgery.⁴⁶¹

Similar to other international jurisdictions, we see from the above discussions that in Australia and the United Kingdom consent is positively viewed as part of a doctor’s duty to care and a failure to obtain informed consent constitutes medical negligence whereas the South African and Canadian approach views a lack of consent as a violation of the patient’s physical integrity.⁴⁶²

The matter of *Adan v Davis*⁴⁶³ highlights how the doctor failed to achieve the standard of informed consent solely on the grounds that he did not fully disclose the sterilization procedure to the patient in a language that she understood.⁴⁶⁴ Dr. Davis also failed to ensure that the patient knew of the alternate contraceptive methods available to her was, or even

⁴⁵⁷ Ibid.

⁴⁵⁸ *Pittman Estate v Bain* (1994) 112 D.L.L. (4th) 27.

⁴⁵⁹ *Adan v Davis* [1998] O.J.NO. 3030

⁴⁶⁰ *Adan v Davis* [1998] O.J.NO. 3030

⁴⁶¹ *ibid*

⁴⁶² A.Dhai, J Gardner, Y .Guidozzi, G. Howarth, M.Voster op cit 64.

⁴⁶³ *Adan v Davis* [1998] O.J.NO. 3030

⁴⁶⁴ *ibid*

inform her of the benefits, risks and/or consequence that followed the sterilization procedure.⁴⁶⁵

There is a general requirement in both national and international jurisdictions that the patient's right to autonomy, liberty, security in and control over their bodies and self-determination is of paramount importance and is in keeping with societal norms and values. As previously discussed, consent legitimizes medical treatment that would otherwise be assault, based on the maxim "*volenti non fit injuria*."⁴⁶⁶

⁴⁶⁵ *ibid*

⁴⁶⁶ *Stoffberg v Elliot* 1923 CPD 148 and *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710, cited in R. Thomas 'Where to from *Castell v De Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and standards of disclosure' (2007) 124 *SALJ* 188 : 'a person may commit the iniuria of assault merely by interfering or attempting to interfere with the body of another'

CHAPTER 4: SOUTH AFRICAN LEGISLATURE, POLICIES AND PRACTICES; LOOKING INTO FLAWS IN MEDICAL PRACTICE

Our South African legislation and policies promise the highest attainable standard of health but there is still a high incidence of medical negligence, domestic violence against women and children, lack of resources and information affording women fast and efficient maternal medical screening and treatment.⁴⁶⁷ Strict adherence to our legislation is not complied with because we still experience incidences of violation against women's sexual and reproductive self-determination.⁴⁶⁸

Stefiszyn states that Article 14 of Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women, (Women's Protocol or Protocol)⁴⁶⁹ ratified by South Africa in 1996, offers a comprehensive protection of women's reproductive rights including issues relating to sexual violence, early marriages and the escalating spread of HIV infections amongst young African women. It is 'the first binding international human rights treaty to guarantee an abortion under qualified circumstances, as well as the right to be protected from HIV infection,⁴⁷⁰ A woman's autonomy is respected when she is empowered by knowledge of her medical status thereby having control over her body and fertility. She has the liberty and security of her person in making informed decisions and medical treatment choices.⁴⁷¹

With the introduction of unaffordable medical indemnity insurance premiums by medical insurance companies, there is a trend for high-risk specialists, namely: gynaecologists and obstetricians, to abandon their field of specialization. The cost of indemnity coverage for individual specialists are estimated to be approximately R800 000-00 per annum owing to the increase in the number of medical negligence case being brought against them.⁴⁷²

Pienaar⁴⁷³ states that the medical negligence claims being brought against doctors are increasing with some of the contributory factors being; the standard of health care has

⁴⁶⁷ Carte Blanche; feature story: 'Haemorrhaging Gauteng Health' Estè de Klerk, Researcher: Jean-Emile@#GautengHealth, available at: cartebalanche.dstv.com/player/951884 (accessed on 22 November 2015).

⁴⁶⁸ Carte Blanche; feature story: 'Haemorrhaging Gauteng Health' Estè de Klerk, Researcher: Jean-Emile@#GautengHealth, available at: cartebalanche.dstv.com/player/951884 (accessed on 22 November 2015).

⁴⁶⁹ Karen Stefiszyn 'Health and reproductive rights, HIV, and the Protocol to African Charter on the Rights of Women in Africa' (2011) 12 (4) *ESR Review*.

⁴⁷⁰ Article 14(2)(c) of the Protocol to African Charter on the Rights of Women in Africa.

⁴⁷¹ Karen Stefiszyn op cit.405

⁴⁷² M. Hesse 'Now local liability cover for doctors' (2016) *Business Report* Available at : <https://www.iol.co.za/business-report/> (accessed 14-09-2017).

⁴⁷³ L. Pienaar 'Investigating the reason behind the increase in medical negligence claims' (2016)1(1) *Scielo* Available at: <http://www.scielo.org.za/scielo.php> (accessed on 30/10/2017).

dropped; a lack of communication between the doctor and the patient; and further, a high percentage of birth-related incidences of negligence.⁴⁷⁴

With the rapid increase in medical negligence claims and the prudent-patient approach adopted in medical practice, medical professionals are seen to practice “defensive medicine” rather than “compassion-centered care” to safe-guard themselves from being sued.⁴⁷⁵ The defensive medicine strategy sees healthcare practitioners requesting more tests and scans in diagnosing the patient’s medical condition.⁴⁷⁶ The focus of medical practice should be invested on patient well-being rather than guarding against potential law suits.

Although the implementation of the general principles and ethical guidelines have been legislated and re-affirmed in the HPCSA guidelines, a recent Medscape Survey⁴⁷⁷ revealed that 85 percent of doctors in the fields of gynaecology and obstetrics are most likely to be sued among all physicians, of which 3 percent admit their failure to follow safety procedures or obtain informed consent. The survey further revealed that 15 percent of specialists, especially in the field of gynaecology and obstetrics, are in the main, reported by their colleagues rather than sued by them.⁴⁷⁸

Carstens and Pearmain contend that in assessing medical negligence in South Africa, one must take into account the subjective training, experience and skill of the attending physician or medical practitioner against the objective circumstances of their locality under which they work and practice.⁴⁷⁹ South Africa’s medical training standards of medical care, access to health care and the availability of resources still remains inadequate, as there are shortages of medical staff and doctors in tribal, community and rural locations.⁴⁸⁰

Doctors and physicians placed at these poorly equipped, rural and primary health care facilities are still obliged to treat their patients with the highest degree of skill and care. Carstens and Pearmain state that South Africa is a developing country, suffers discrepancies in the level of services due to lack of resources and infrastructure which compromises service delivery and affects the informed consent process.⁴⁸¹ Our South African community needs law enforcement strategies that are able to ensure the proper use of allocated budgets

⁴⁷⁴ Ibid.

⁴⁷⁵ Ibid.

⁴⁷⁶ Ibid.

⁴⁷⁷ Carol Peckham ‘Medscape Malpractice Report 2015. Why most doctors get sued.’ 9 December 2015

<http://www.medscape.com/features/slideshow/public/malpractice-report-2015#page=3> accessed 14-09-2017.

⁴⁷⁸ Ibid.

⁴⁷⁹ Carstens and Pearmain op cit. 59

⁴⁸⁰ Ibid.

⁴⁸¹ Carstens and Pearmain op cit.59

financially support, supply and cater for the needs of its citizens by providing first world standards and health facilities. The strict adherence to our legislature, policies and practices by all parties concerned will successfully attain a higher quality health status and will reduce the law suits and claims being brought against the medical professionals by their patients and/or their representatives for poor and sub standard service delivery.

The Health Professional Council of South Africa (HPCSA) is a statutory body, which was established under the Health Professions Act⁴⁸² to regulate the profession. The council formulated standards and rules by which the health professionals ought to ethically practice their profession. The HPCSA guidelines and regulations are binding on its members and are used as a basis for identifying unprofessional conduct for disciplinary enquiry.⁴⁸³

Disregard for the HPCSA protocol⁴⁸⁴ was shown by the defendant in the case of *Isaacs v Pandie*⁴⁸⁵ where the defendant testified that although he conducted his sterilization procedure according to the HPCSA guidelines, he does not usually take written consent from a patient in hospital, nor does he check and verify the signatures of his patients on the consent forms.⁴⁸⁶ The defendant further admitted in his testimony that he was unaware of whether or not his colleagues took written consents from patients in hospital and/or checked the signatures on those consent forms as well. The court held that requirements were not met, that the defendant had failed to obtain a written consent and acted negligently in failing to check the consent forms as procedurally required by the HPCSA.

In addressing the *Isaac* case, Samela, J found that the defendant failed to adhere to both the legislation and the HPCSA Regulations. The court held that the defendant had a mandate based on their contractual relationship entered into by himself and the plaintiff and was further under a legal obligation to obtain informed consent in terms of the Sterilization Act.⁴⁸⁷ Traditionally, in the field of gynaecology and obstetrics, the first scan performed by the doctor or ultrasound is conducted, seemingly as a routine procedure without informed consent

⁴⁸² Health Professions Act 56 of 1974.

⁴⁸³ Booklet 9, Section 2. 1 of the HPCSA: *Seeking Patient's informed consent: The Ethical Considerations* (2008) guidelines state that: ' Successful relationship between health care practitioners and patients depend upon mutual trust. To establish that trust practitioners must respect patient autonomy- their right to decide whether or not to undergo any medical intervention, even where a may result in harm to themselves or in their own death. Patients must be given sufficient information in a way that they can understand, to enable them to exercise their right to make informed decisions about their care. That is what is meant by informed consent.'

⁴⁸⁴ Booklet 9, Section 10 of the HPCSA: *Seeking Patient's informed consent: The Ethical Considerations* (2008)

⁴⁸⁵ *Isaacs v Pandie* supra 197.

⁴⁸⁶ *Ibid.*

⁴⁸⁷ *Isaacs v Pandie* supra 197.

being legally obtained prior to the ultrasound procedures being conducted.⁴⁸⁸ These patients are led to believe that it is a normal, positive routine ante-natal medical procedure where the expectant mother looks in anticipation to view her baby's little hands or feet. The actual reason for scanning is a negative one primarily because the gynaecologist is looking for abnormalities, handicaps or defects. Should defects and or abnormalities be detected then the expectant mother will likely be offered the option of tests and finally abortion.⁴⁸⁹

Howarth⁴⁹⁰ identified the high probability of obstetric and gynaecology litigation in the future, especially in the area of "obstetric ultrasound and cervical cytology" and warns against doctors relying on the fact that their peers have traditionally by-passed the moral and mandatory procedure of first obtaining informed consent from the patient prior to interventions.⁴⁹¹

Stefiszyn discusses the trauma effecting women subject to a sterilization procedure and states that compulsory, forced and coerced sterilization affects women both physically and emotionally. It further infringes upon her womanhood and her freedom to control her fertility, including her 'rights to liberty, bodily integrity, the right to be free from discrimination.'⁴⁹² Stefiszyn asserts further, that research conducted in Namibia by the International Community of Women Living with AIDS, showed that in those cases of forced sterilization or coerced sterilization, informed consent was not properly obtained. It illustrated that the consent was invalid as it was obtained under duress or in circumstances where a full disclosure of the medical treatment and intervention was absent. The women were led to believe that they would benefit from other medical procedures like abortions or Caesarian section delivery, only if the consent to sterilization procedure was signed.⁴⁹³

Once again we see the growing need to create awareness, regulate and mandate medical professionals to incorporate as routine practice of obtaining informed consent within the field of gynaecology and obstetrics. The post-trauma both emotionally and physically has far reaching consequences and we should endeavor to create awareness and training amongst medical professionals by educating them on the invaluable implementation and adherence to the doctrine of informed consent.

⁴⁸⁸ SASUOG, Consent for early "routine" obstetric ultrasound : <http://sasuog.org.za/consentforear.asp> (accessed 14 November 2015).

⁴⁸⁹ Ibid.

⁴⁹⁰ Ibid.

⁴⁹¹ Ibid.

⁴⁹² Karen Stefiszyn 'Health and reproductive rights, HIV, and the Protocol to African Charter on the Right's of Women in Africa' (2011) 12 (4) *ESR Review* pages 3 -5.

⁴⁹³ Ibid.

Chapter 5: CONCLUSION AND RECOMMENDATIONS

Having regard for our common law rights embodied in the Bill of Rights under the Constitution of the Republic of South Africa,⁴⁹⁴ especially the right to dignity, psychological, bodily integrity and security, all protected and supported by NHA⁴⁹⁵, the HPCSA⁴⁹⁶ Guidelines create a platform for a proper functioning health care system. Doctors have a legal responsibility and obligation to fully disclose all inherent risks, benefits, and alternatives prior to treatment. This study concludes that healthcare practitioners, especially those in the specialized field of gynaecology and obstetrics are inconsistent in their approach to informed consent despite their ethical and legal mandate.

It is widely accepted that a patient who is informed about their health status, is able to exercise their autonomy and self-determination in choosing treatment options and remedies or may even choose to forego medical treatment altogether.⁴⁹⁷ In the previously discussed cases of *LM and OTHERS v Government of the Republic of Namibia*⁴⁹⁸, *Christian Lawyers Association v Minister of health and Others*⁴⁹⁹ and *Isaac v Pandie*⁵⁰⁰ the courts took note of women's reproductive rights and their right to bodily integrity. In *Christian Lawyers Association v Minister of health and Others* the Appeal court examined aspects of the right, including the patient's capacity, to provide the necessary informed consent.⁵⁰¹ In *Isaac v Pandie* the courts took into consideration the patient's mental and emotional state, including their pain and suffering and loss of amenities of life. It was further held in both the *LM and OTHERS v Government of the Republic of Namibia*⁵⁰² and *Isaac v Pandie*⁵⁰³ that it was the doctor's duty to obtain informed consent from the patient; further, the court referred to the HPCSA guidelines which ' expressly states that it is responsibility of the doctor providing treatment to his/her patient to obtain consent' and remains responsible for ensuring that the patient is given ample time to the understand the medical intervention, to consider the

⁴⁹⁴ Act No. 108 of 1996.

⁴⁹⁵ National Health Act 61 of 2003

⁴⁹⁶ Health Professions Council of South Africa (HPCSA) guidelines for good practice in the health care profession- seeking patients informed consent : The ethical considerations 2nd edition (HPCSA Pretoria 2008)

⁴⁹⁷ Ibid.

⁴⁹⁸ *LM and Others V Government of the Republic of Namibia* 2012 NAHC 211

⁴⁹⁹ *Christian Lawyers Association v Minister of health and Others (Reproductive Health Alliance as Amicae Curaie)* 2005 (1) SA 509 (T)

⁵⁰⁰ *Isaac v Pandie* 2012 ZAWCHC 47

⁵⁰¹ *Christian Lawyers Association v Minister of health and Others (Reproductive Health Alliance as Amicae Curaie)* 2005 (1) SA 509 (T)

⁵⁰² *LM and Others V Government of the Republic of Namibia* 2012 NAHC 211

⁵⁰³ *Isaac v Pandie* 2012 ZAWCHC 47

benefits, risks and consequences of the medical intervention, to make an informed decision and to either grant or refuse consent.⁵⁰⁴

Also noteworthy to mention, is the use of therapeutic privilege invoked by the doctor in the abovementioned case of *VRM ibid*. The doctor contended that he choose not to inform the patient of his decision to test her for HIV, as he did not want to impart information which was likely to affect her psychological and emotional state during the late stages of her pregnancy. This argument proved unsuccessful as the protocol in treating and dealing with people living with HIV, along with statutory requirements pertaining to HIV incidences with in South Africa, does not cater for the defense of therapeutic privilege. An infection with HIV is a deeply serious piece of health information, not only for the patient but also for society as a whole. The woman diagnosed with HIV has a legal duty to inform her partner of her status.⁵⁰⁵

The defense of therapeutic privilege is unavailable for medical practitioners in situations where a patient consents to a particular procedure for an anticipated outcome or contingent upon a diagnosis. Patrick Van den Heever suggests that therapeutic privilege can be successfully used in treating patient's suffering from psychiatric illness and where disclosure would cause serious harm to the patient. Doctors are therefore warned against fully disclosing medical information to those patients who present with signs or a likelihood of being unable to make rational decisions or choices. Further, a doctor who has invoked therapeutic privilege must show strong ground upon which they invoked it and they bear the onus of proving that a non-disclosure supports the best interest of the patient and protects patient autonomy.⁵⁰⁶ I believe that full disclosure supports the best interest of the patient as it promotes self-determination and patient autonomy.

Although the NCA⁵⁰⁷ and the HPCSA⁵⁰⁸ has implemented guidelines regulating the healthcare practitioners ethical and legal obligations, I believe that there is a dire need for introducing ethical, legal and communication during medical training at both undergraduate and post-graduate levels. With advent of increasing number of medical negligence cases, one can only conclude that healthcare practitioners have limited knowledge of the legal and ethical requirements of informed consent or that they choose to be non compliant with consent regulations. Creating a platform for education and awareness of past and current medical negligence cases amongst the medical professionals will encourage them to implement

⁵⁰⁴ *ibid*

⁵⁰⁵ *Ibid*.

⁵⁰⁶ Patrick van den Heever 'Pleading the defense of therapeutic privilege' (2005) 95 *SAMJ* 421.

⁵⁰⁷ National Health Act 61 of 2003

⁵⁰⁸ Health Professions Council of South Africa (HPCSA) guidelines for good practice in the health care profession-seeking patients informed consent : The ethical considerations 2nd edition (HPCSA Pretoria 2008)

methods and use avenues to prevent the recurrence of similar or same medical negligence issues.

One can strongly recommend that the faculties at Medical Colleges draw courses from the Social Sciences by way of introduction of a whole new module on communication skills,⁵⁰⁹ psychosocial, socio-economically informed people-skills training, to specifically educate medical practitioners of their ethical obligations and of best practice towards their patients and their rights. My suggestion is derived from the courts findings in the case of *Adan v Davis*⁵¹⁰ where it was asserted that not only do doctors have the duty to be culturally informed and to ensure that their patients fully understand the information that is imparted to them but also in situations where an interpreter is used, he or she must be attentive to the linguistic ability of the interpreter and ensure that the message is correctly conveyed by such interpreter.⁵¹¹ As previously mentioned, the court in the case of *Jansen van Vuuren and Another NNO v Kruger*⁵¹² held that the patients have the right to expect that their doctor complies with the professional guidelines therefore in keeping with the ethical guidelines, hospital consent forms must be redrafted to include the space for a written verification by the doctor or surgeon that informed consent was received for the procedure. This will ensure that the doctor did not use a delegate, like a nurse, to obtain the consent, he or she will be obliged to check and confirm that the consent or refusal of the procedure is granted and is on file prior to the procedure.

The reinforcement of ethical and legal requirements must be incorporated throughout both practical and theoretical medical training, with a mind towards improving the status quo of cases of medical negligence. Although, the current courses dealing with community medicine and hospital placements may attempt to prepare graduating doctors to enter the field, they are inadequately equipped to deal with legal obligations, language barriers, cultural barriers stemming from differing norms and beliefs,⁵¹³ socioeconomic circumstances of disadvantaged people, lack of resources within medical facilities, and still maintain a professional level of respect for patient autonomy and self-determination. Our doctors need a curriculum that deviates from a purely clinical background. Medical colleges need to arm graduates with unambiguous practice guidelines,⁵¹⁴ educate them on uniformity of services and processes⁵¹⁵

⁵⁰⁹ L.C.Coetzee op cit 277

⁵¹⁰ *Adan v Davis* [1998] O.J.NO. 3030

⁵¹¹ *ibid*

⁵¹² *Jansen van Vuuren and Another NNO V Kruger* (657/91)(1993) ZA SCA 1450; 1993(4) SA 842(AD);(1993) 2All SA 619 (A)

⁵¹³ Ames Dhai and D J McQuoid- Mason op cit 14 at 82.

⁵¹⁴ G.Howarth and P. Carstens op cit.55

and to help adapt them to our heterogeneous South African nation and its needs by adapting their training to safeguard their patients and to safeguard their own careers given the increasing rate of claims against them. Efforts must be implemented to work towards affording patients with safe and effective treatment and to ultimately use the professional skills of our medical experts towards the best interest of the patient firstly.

Currently, gynaecologists and obstetricians are considered high-risk specialists who are expected to pay higher medical indemnity insurance premium in the face of escalating medical malpractice and medical negligence claims being brought by patients, or by children disabled at birth, for example.⁵¹⁶

Practicing such a high risk specialty, in a country with limited resources but first world guarantees to service, these specializations have little choice but to incorporate into their curriculum, the people skills that would allow them to close the gap between what is promised and what is delivered to patients.

Finally, to confidently answer the question: Apart from medical emergencies, when is it justified for gynaecologists, and obstetricians to deviate from informed consent without reverting back to their patients? One can only re-affirm that health practitioners cannot materially change the preauthorized medical plan of action or the terms of the consent, especially if the new treatment radically alters the patient's health status. The doctrine of informed consent is a widely acknowledged obligation placed on the medical fraternity to ensure patient autonomy and sexual and reproductive self-determination is adhered to and respected. Gynaecologists and obstetricians cannot deviate from their mandate unless it is a medical emergency or their patients have voluntarily waived their rights to consent or where the healthcare practitioner is faced with a situation as described in terms of Section 7 of the National Health Care Act.⁵¹⁷

⁵¹⁵ Ibid.

⁵¹⁶ Now local liability cover for doctors 2016, Business Report, Accessed 14-09-2017
<https://www.iol.co.za/business-report/now-local-liability-cover-for-doctors-2095202> accessed 14-09-2017.

⁵¹⁷ Section 7 of the National Health Act 61 of 2003.

Informed consent within the field of gynaecology and obstetrics is an integral part of the diagnostic-therapeutic process, and legitimizes the treatment process by granting the power of informed self-determination to the patient. A woman's right to bodily integrity and autonomously pursue reproduction is consistent with section 12(a) of the Constitution ' to make decisions concerning reproduction'⁵¹⁸

With the development of the doctrine of informed consent in our South African law and international law, Gynaecologists and obstetricians must deviate from the historical practice of medicine in accordance with the Hippocratic customs, which encourages paternalism and the imbalance of power, including gender-relations and create a platform wherein female patient can exercise their autonomy during their treatment process, during their pregnancy, childbirth or healing process.

⁵¹⁸ Especially section 12(2) (a) : 'Everyone has the right to bodily and psychological integrity which includes the right: (a) to make decisions concerning reproduction; (b) to security and control over their bodily; and (c) not be subject to be subject to medical or scientific experiments without their informed consent'

BIBLIOGRAPHY.

CONSTITUTION

1. The Constitution of the Republic of South Africa Act No. 108 of 1996

STATUTES

SOUTH AFRICA

1. The Children's Act 38 of 2005
2. The Choice of Termination of Pregnancy Act 92 of 1996
3. The Criminal law (Sexual offences and related matters) Amendment Act No. 32 of 2007
4. The National Health Act 61 of 2003
5. The Sterilization Act 44 of 1998
6. The Health Professions Council of South Africa (HPCSA) Guidelines '*Ethical and Professional rules of the Health Professions Council of South Africa as promulgated in Government Gazette R717/2006* Booklet 2, 27 A (c) available at www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_2_generic_ethical_rules_with_anexures.pdf (accessed 19 November 2015)

INDIA

1. The Indian Penal code Act No. 45 of 1860
2. Indian Medical Council (Professional Conduct, Ethics, & Etiquettes) Regulations -2002.
<http://old.miindia.org/RulesandRegulations/codeofmedicaethicsregulations2002> (accessed 01/06/2015)
3. The Indian Contract Act of 1872

CASE LAW

SOUTH AFRICA

1. *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1793 (1) SA 769 (A)
2. *Broude v McIntosh* (1998) (3) SA 60
3. *Broude v McIntosh* (1998) ZASCAC28; 1998 (3) SA 60 (A)
4. *Boyce v Member of the Executive of Council for Health, Eastern Cape Government and another* [2001] JOL 9139 (Tk)
5. *C v Minister of Correctional Services* 1996 (4) SA 292 T
6. *Castell v de Greef* 1993 (3) SA 501 (C)
7. *Castell v de Greef* 1994(4) SA 408 (C)
8. *Christian Lawyers Association v Minister of health and Others (Reproductive Health Alliance as Amicae Curaie)* 2005 (1) SA 509 (T)
9. *Esterhuizen v Administration Transvaal* 1957 (3) SA 710 (T)
10. *F v R* (1983) 33 SASR.

11. *Isaac v Pandie* 2012 ZAWCHC 47
12. *Jansen van Vuuren and Another NNO v Kruger* (657/91)(1993) ZA SCA 1450; 1993(4) SA 842(AD);(1993) 2All SA 619 (A)
13. *Lymbery v Jefferies* 1925 AD 236
14. *Lowrens v Oldwage* 2006 (1) SA 161 (SCA)
15. *McDonald v Wroe* (2006) 3 All SA 565 (C)
16. *Oldwage v Lowrens* supra 532 2006 91) SA 161 (SCA)
17. *Pandie v Isaac* (2013) ZAWCHC 123
18. *Pane v MEC Free State Department of Health* (2016) ZAFSHC99
19. *Reibl v Huges* (1980) 2 SCR 8 (1980) 2 SCR 880 Supreme Court of Canada
20. *Richter v Estate Hamman* 1976 (3) SA 226 (C)
21. *Sibisi NO v Maitin* 2014 (6) SA533 (SCA) A
22. *SA Medical and Dental Council v McLouglin* 1948 (2) SA 355 (A)
23. *Stoffberg and Elliot* 1923 CPD 128
24. *Soobramoney v Minister of Health (Kwa Zulu Natal)* (CCT 32/97) (1997) ZACC 17; 1998(1) SA 765 (CC); 1997(12) BCLR 1696 (27 NOVEMBER 1997)
25. *Van Wyk v Lewis* 1929 AD 458
26. *VRM v Health Professions Council of South Africa* (2001) (T) unreported (2003) JOL 11944(T)

UNITED KINGDOM

1. *Al Hamwi v Johnston and Another* (2005) EWHC 206
2. *B v NHS Hospital Trust* (2002) 2
3. *Birch v University College London Hospital NHS Foundation Trust* (2008) EWHC 2237(QB)
4. *Bolam v Friern Barnet Hospital Management Committee* (1957) 1 WLR 582; (1957) 2 All E 118 (QBD)
5. *Chester v Afshar* (2002) 3 All ER 552
6. *Montgomery v Lanarkshire Health Board* (2015) UKSC 11
7. *Pearce v United Bristol Healthcare NHS Trust* (1998) E and WCA 2243 (20th May 1998)
8. *Sidaway v Board of Governors of Bethlem Royal Hospital* 1985 All ER [1984] 1 All ER 1018
9. *Sidaway v Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* (1985) All ER 643 (HL)
10. *Smith v Tunbridge Wells Health Authority* (1994) 5 Med L.R.334

AUSTRALIA

1. *Battersby V Tottman and The State of South Australia* (1985) 37 SASR 524
2. *Chappel v Hart* (1998) 156 CLR 517
3. *Rogers v Whittaker* (1992) 175 CLR 479
4. *Teik Huat Tai v Saxon* (1996) WASC No. 23/95

CANADA

1. *Adan v Davis* [1998] O.J.NO. 3030
2. *Hopp v Lepp* (1980) 2 SCR 192
3. *Pittman Estate v Bain* (1994) 112 D.L.L. (4th) 27

GERMANY

1. *BGH* 25.4.1989 VI.ZR 175/88 BGHZ 107 222

NAMIBIA

1. *LM and Others V Government of the Republic of Namibia* 2012 NAHC 211
2. *Government of the Republic of Namibia v LM and OTHERS* (SA49/ 2012) [2014] NASC 19 (3 November 2014).

INDIA

1. *Samira Kohli v Prabha Manchanda Dr. & ANR* 1 (2008)CPJ 56 (SC)

UNITED STATES OF AMERICA

1. *Canterbury v Spence United States Court of Appeals for the District of Columbia Circuit* 464 f.2d 772 (1972) U.S
2. *Tatro v Leuken, Kan* 512 P 2D 529 (1973)

TEXTBOOKS

1. Dhali A and McQuoid D - *Mason Bioethics, Human Rights and Health Law: Principles and Practice* (2011) Juta & Co. Cape Town
2. Mason JK and Laurie GT *Law and Medical Ethics* (2011) 8th ed
3. Malcom JG *Treatment choices and Informed Consent: Current Controversies in Psychiatric Malpractice Litigation* (1988) Butterworths, Springfield , Illinois
4. Carstens P and Pearmain D *Fundamental Principles of South African Medical Law* (2007) Lexis Nexis , Cape Town
5. Piver JS *Preparing and winning Medical negligence cases: Gynaecology, Medical Negligence cases*, 3rd Edition (April 17, 2009) JUNS Publishing , New York
6. Dada MA and McQuoid-Mason DJ 'Introduction to Medico-Legal Practice' (2001) Butterworths, Durban
7. Powers M and Harris N *Clinical Negligence* 2nd ed (1994)Butterworths , London

8. Fried RG and Perlis C *Therapeutic privilege: If, when, and how to lie to patients Dermatoethics* 2012 Chapter 10 , Editor : Bercovitch, L and Perils, C , Publisher Springer- Verlag London Ltd, London
9. Strauss S.A '*Doctor, Patient and the Law: A Selection of Practical Issues*' 3ed (1991) Van Schaik Publishers, Pretoria
10. Hoppe N and Miola J *Medical law and Medical Ethics* (2014) *Cambridge Press*, Cambridge

THESES

1. Van Oosten FFW 'The Doctrine of informed consent in Medical Law' (1991) Unpublished LLD
2. Coetzee LC ' Medical Therapeutic Privilege' Masters in Law, University of Pretoria, November 2001

MONOGRAPHS

1. HPCSA Guidelines for good practice in the health care professions, 'Seeking patient's Informed Consent: The Ethical Considerations' Booklet 9
www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_2_generic_ethical_rules_with_anexures.pdf (accessed)19 November 2015
2. The Health Professions Council of South Africa (HPCSA) Guidelines 'Ethical and Professional rules of the Health Professions Council of South Africa' *as promulgated in Government Gazette R717/2006* Booklet 2, 27 A (c) available at:
http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_2_generic_ethical_rules_with_anexures.pdf (accessed 19 November 2015)
3. HPCSA, *Guidelines for the Withholding and Withdrawing of Treatment*, 2nd ed (2007)

JOURNAL ARTICLES

1. Dhai A, Gardner J, Guidozi Y, Howarth G, Vorster M 'Vaginal Deliveries- is there a need for documented consent?' (2011) 101:1 *SAMJ* 20-22
2. Das A, Rai R, Singh D 'Medical Negligence and Rights Violation' (2004) *Economic and Political Weekly*, 3876-3879.
3. Marsh BT 'Informed Consent- help or hindrance?' (1990) *Journal of the Royal Society of Medicine J R Soc Med.* 83 vol 3
4. Tay CSK 'Informed Consent in Obstetrics and Gynaecology'(2007) 7:1 *HKJGOM* 43-46

5. van Wyk C 'Pregnancy and HIV in South Africa: Women's rights to be informed' (2007) 70 *Tydskrif HRHR* 584-595.
6. McQuoid-Mason D 'An introduction to aspects of health law: bioethical principles, human rights and the law' (2008) 6 (1) *South African Journal of Bioethics and Law*
7. McQuoid-Mason D 'Medical ethics and the payment of fees before treatment' (2011) 101 (11) *SAMJ*
8. McQuoid-Mason D 'Establishing liability for harm caused to patients in a resource-deficient environment' (2010) 100(9) *SAMJ* 573
9. McQuoid-Mason D 'An introduction to aspects of health law: bioethical principles, human rights and the law' (2008) 1 (1) *SAJBL* 7-10
10. McQuoid-Mason D & Dada MA 'The National Health Act: Some implications for Family Practice' (2006) 24 *CME* 12-14
11. McQuoid-Mason D 'The National Health Act and refusal of consent to health services by children' (2006) 96 (6) *SAMJ* 530-532
12. Monaghan C 'Does the Doctor know best? A Deconstruction of informed Consent' (2017) 4 (2) *IALS Student Law Review* 25-30
13. van Oosten F 'The Doctrine of Informed consent in Medical Law' (1989) 52-53 As cited by van den Heever P 'Therapeutic privilege in the South African medical law' (1993) *De Rebus* 624 -626
14. Howarth GR, Mulder P, Jeffery B 'Consent for early "routine" obstetric ultrasound' *South African Society for ultrasound in Obstetrics and Gynaecology*
15. Stefiszyn K 'Health and reproductive rights, HIV, and the Protocol to African Charter on the Rights of Women in Africa' (2011) 12:4 *ESR Review* 3-5
16. Coetzee LC and Carstens P, 'Medical Malpractice and Compensation in South Africa' (2011) 86 *Chi-Kent.L.Rev.* 1263
17. Ogunbanjo GA and Knapp van Bogaert D 'Ethical issues in family practice: Informed consent- Disclosure of information in Clinical Practice' (2004) 46(3) *SA Fam Prac* 35-37
18. van den Heever P 'Pleading the defense of therapeutic privilege' (2005) 95 *SAMJ* 421
19. Pepper MS, Slabbert MN 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 (1) *South African Journal of Bioethics and Law* 29-35

20. Morton WJ 'The Doctrine of informed consent Medicine and Law' 6 (2) 117- 125 on 121 Medicine and Law Journal
21. Appelbaum PS and Grisso T 'Assessing patient's capabilities to consent to treatment' (1988) *N Engl J Med* 319 (11)
22. Lankton, Batchelder and Ominsky 1977 'Emotional responses to detailed risk disclosure for anesthesia, a prospective randomized study' *Anesthesiology* 294 vol 46 (4) 294-296
23. Denney, Williamson & Penn 1975:205
24. Howarth GR 'The threat of litigation: Private obstetric care-quo vadis?' (2011) 4 (2) *South African Journal of Bioethics and Law* pgs. 85-88
25. Singh D 'Informed vs. Valid Consent: Legislation and Responsibilities' *Indian Journal of Neuropathy (IJNT)* (2008)5 (2)
26. ACOG Committee on Ethics: Ethics in Obstetrics and gynaecology, 2nd ed "Patient Choice in the maternal-fetal relationship" Washington DC : *The American College of Obstetricians and Gynecologists* (2004)
27. Almand AI 'A Mother's worst nightmare. What's left unsaid the lack of informed consent in Obstetrical practice'(2012) 18:3 *William and Mary Journal of Women and the Law* 565-594
28. Coldicott Y, Pope C, Roberts C 'The Ethics of intimate examinations- Teaching tomorrow's doctors' (2003) *British Medical Journal* 326 (7380); 97-101
29. Jamieson DJ, O'sullivan MJ, Maupin R, Weber MP, Nesheim S, Lampe M, Garcia P, Lindsay M, and Bulterys M 'The challenges of informed consent for rapid HIV testing in labor' (2003) 12:9 *Journal of Women's Health* 889-895
30. KK Agarwal ' Real consent and not informed consent applicable in India' *Indian Journal of Clinical Practice* (2014) 25 (4) Medilaw pg. 392-393, medind.nic.in/iaa/t14/i9/iaat14i9/p392.pdf (accessed 03-05-2018)
31. Asresash D. Abathum, Abdi A. Gele, Johanne Sundby Attitude towards the Practice of Female cutting among school Boys and Girls in Somali and Harari regions Eastern Ethiopia, Available at : <https://www.hindawi.com/journals/ogi/2017/1567368/> (accessed 15-10-2018)

INTERNET

32. Kohli A 'Medical Consent in India- Ethical and legal issues ' Anil Aggrawal's Internet Journal of Forensic Medicine and Toxicology (2007) 8 (2) available at: www.anilaggrawal.com (accessed 15 May 2015)
33. Shaw D 'Understanding the relevance of sexual and reproductive rights to professional responsibilities' JOGC DEC2004 1095 available at: www.researchgate.net/publication/8035317 (accessed 15 May 2015)
34. 'Ultrasound in Obstetrics and Gynaecology' SASUOG, available at: <http://sasuo.org.za/consentforear.asp> (accessed 14 November 2015)

35. De Bord J 'Informed Consent: Ethics in Medicine' University of Washington School of Medicine, available at: bioethx@u.washington.edu (accessed 16 May 2015)
36. Skene L, Smallwood R 'Informed consent: lessons from Australia' *BMJ* 2002 Jan 5; 324(7328): 39-41 available at: ncbi.nlm.gov/pmc/articles/PMC1121943/ (accessed 1 June 2015)
37. Carstens PA 'Informed consent in South African medical law with reference to legislative developments' *The South African Medico legal Society*, available at: <http://www.new.sami.co.za/node/410> (accessed 22 November 2015)
38. Sidin AI 'The obstacles of valid informed consent' (2016) 3 (5) *International Invention Journal of medicine and Medical Sciences* ISSN: 2408-72460 (accessed 09-10-2017)
39. Carte Blanche; feature story: 'Hemorrhaging Gauteng Health' Estè de Klerk, Researcher: Jean-Emile@#GautengHealth, available at: <http://www.carteblanche.dstv.com/player/951884> (accessed on 22 November 2015) video
40. SASUOG, Available at : <http://sasuo.org.za/consentforear.asp> (accessed 14 November 2015)
41. Perumal Y 'Hospital blamed for deaths of mum and unborn baby' available at: <https://risingsunchatsworth.co.za/55084/> (accessed 06 October 2017)
42. Perumal Y 'Croftdene mum and baby's post mortem results revealed' available at: <https://risingsunchatsworth.co.za/57692/>
43. Howarth G and Carstens P 'Can private obstetric care be saved in South Africa? (2014)7(2) *SAJBL* , Available at: <http://www.sajbl.org.za/index.php/sajbl/article/> (accessed 21 September 2017)
44. Buechler JE 'Informed Consent Challenges in Obstetrics' *CRICO/RMF*(2007) <https://www.rm.harvard.edu/~mediafiles> (accessed 19 November 2015)
45. Black M 'Vaginal birth comes with risks too- so should it really be the default option?' *The Conversation*(2016) <http://theconversation.com/> (accessed: 21 September 2017)
46. Ndaliso C and Dawood Z 'Baby dies over hospital space' <https://www.iol.co.za/news/south-africa/kwazulu-natal/>
47. Siso S 'Woman forced to give birth outside clinic' Available at: <http://citizen.co.za/342977/woman-forced-to-give-birth-outside-clinic/> (accessed 2 November 2015)
48. Wicks J 'Dying man turned away from two hospitals-paramedics' Available at: <http://www.news24.com/southafrica/news/dying-man-turned-away-from-two-hospitals-paramedics-20150713> (accessed 2 November 2015)

49. Cardoso R, Zarin W, Nincic V, Barber SL, Gulmezoglu A M, Wilson C, Wilson K, McDonald H, Kenny M, Warren R, Straus S. E, Tricco A.C 'Evaluation reports on medical malpractice policies in obstetrics: A rapid scoping review' <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5586050> (accessed 09 October 2017)
50. 'Gynaecologist jailed for five years following death of a patient', available at: <https://www.iol.co.za/news/SouthAfrica/mpumalanga/> (accessed 14 September 2017)
51. 'Doctor in botched birth will know fate this week' Available at: <http://www.news24.com/SouthAfrica/News> (accessed 14 September 2017)
52. Harberfield L 'Informed consent and infant male circumcision' Available at: <http://www.cirp.org/library/legal/harberfield> (accessed 25-10-2017)
53. Tidy C 'Consent to treatment in children' Mental capacity and Mental Health Legislation' (2015) Available at: <https://patient.info/doctor> (accessed 14-09-2017)
54. Hesse M 'Now local liability cover for doctors' (2016) *Business Report* Available at: <https://www.iol.co.za/business-report/> (accessed 14-09-2017)
55. Peckham C 'Medscape Malpractice Report 2015. Why most doctors get sued.' 9 December 2015 Available at: <http://www.medscape.com/features/slideshow/public/malpractice-report-2015#page=3> (accessed 14 September 2017)
56. Pienaar L 'Investigating the reason behind the increase in medical negligence claims' (2016)1(1) *Scielo* Available at: <http://www.scielo.org.za/scielo.php> (accessed on 30 October 2017)
57. 'Now local liability cover for doctors 2016' Business Report <https://www.iol.co.za/business-report/now-local-liability-cover-for-doctors-2095202> (accessed 14 September 2017)
58. Raab EL 'The parameters of informed consent' <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1280103/> (accessed 09 October 2017)
59. Gogos AJ, Clark RB, Bismark MM, Gruen RL, Studdert DM 'When informed consent goes poorly: a descriptive study of medical negligence claims and patient complaints' (2011) *Med J Aust.* <https://www.ncbi.nlm.nih.gov/pubmed/21929499>
60. Glaser LM, Alvi FA, Milad MP ' Trends in Malpractice claims for obstetric and gynaecologic procedure, 2005 through 2014' (2017) 9 *Am J Obstet Gynaecol* <https://www.ncbi.nlm.nih.gov/pubmed/28549980>
61. Chima SC ' Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) 12 <https://www.bmcmedcentral.com/articles/10.1186/1472-6939-14-SI-S3> (accessed 25/10/2016)

62. S.C. Chima “Because I want to be informed, to be part of the decision- making”: Patient’s insights on informed consent practices by healthcare professionals in South Africa. [Http://www.njcponline.com/article](http://www.njcponline.com/article). (accessed 25/10/2016)
63. G.I. Serour ‘Medicalization of Female genital mutilation/cutting’ (2013) 19 (3) *African Journal of Urology* Available at: <http://www.sciencedirect.com/science/> (accessed on 08-10-2017).
63. Definition of “SSS” ¹<https://en.wikipedia.org> “ Sub clavian Steal Syndrome (SSS) also called Sub clavian Steal Phenomenon or Sub clavian Steal Steno-occlusive disease, is a constellation of signs and symptoms that arose from reversed blood flow in the vertebral artery or internal thoracic artery, due to a proximal stenosis narrowing and /or occlusion of the sub clavian artery.” (accessed 25/10/2016)
64. Unicef Health Budget: South Africa 2017/2018 , Available at https://www.unicef.org/esaro/UNICEF_South_Africa_--_2017_--_Health_Budget_Brief.pdf (accessed 15 October 2018)
65. Health care in England Available at: https://en.wikipedia.org/wiki/Healthcare_in_England (accessed 15 October 2018)
66. Health care in Canada, Available at : <https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/health-care-card.html> (accessed 15 October 2018)
67. India healthcare: Will the ‘world’s largest’ Public scheme work? Available at: <https://www.bbc.com/news/world-asia-india-42914071> (accessed 15 October 2018)
68. India is introducing free health care –for 500 million people, Available at: <https://www.newsweek.com/india-introducing-free-healthcare-500-million-people-1075607> (accessed 15 October 2018)
69. Asresash D. Abathum, Abdi A. Gele, Johanne Sundby Attitude towards the Practice of Female cutting among school Boys and Girls in Somali and Harari regions Eastern Ethopia, Available at : <https://www.hindawi.com/journals/ogi/2017/1567368/> (accessed 15-10-2018)
70. Barbara Kutui, Africalaw ‘Advancing the rule and role of law in Africa’ Available at : <https://africlaw.com/2012/06/07/female-genital-mutilation-in-south-africa/> (accessed 15/10/2018)

TREATIES AND CONVENTIONS

1. The World Medical Association Declaration of Geneva (1948) cited in Dhai A and McQuiod D - *Mason Bioethics, Human Rights and Health Law: Principles and Practice (2011)* Juta & Co. Cape Town
2. The World Medical Association (WMA) International Code of Medical Ethics, Available at: www.wma.net/en/40news/20archives/2000/2000_18index.html (accessed 14-09-2017)
1. International Covenant on Civil and Political Rights https://en.wikipedia.org/wiki/international_Covenant_on_Civil_and_Political_Rights (accessed 15 May 2015)