

UNIVERSITY OF PRETORIA

FACULTY OF LAW

DEPARTMENT OF PUBLIC LAW

# The Doctrine of Informed Consent in South African Medical Law

Avi Barit

Student Number: 27161316



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## Chapter 1

### Informed Consent

Modern medicine allows us to do amazing things. Medical professionals are able to treat and cure diseases that just a few years ago would have meant certain death. These medical advances have come about at a time when society as a whole is changing the way that it views the medical profession. No more do people wish to merely be treated, they now want to be in control of their own treatment and in control of their own bodies.<sup>1</sup>

This autonomy of the individual has become one of the pinnacle foundations that the ethics of medicine is based on<sup>2</sup>. The medical profession has undoubtedly been affected by this. This is most noticeable in the way that patients expect doctors to explain procedures before they are performed and expect doctors to ask for permission before carrying out any procedure. This explains why the concept of informed consent is so important in today's society. Paternalistic medicine has been completely abandoned and in its place we have medical users who use the medical professionals as consultants to help them make decisions.

It is noteworthy that the South African law has already been shaped in such a way as to account for autonomy of the individual. The different levels of law in South Africa, starting with the Constitution and going through legislation and case law are all in line with the modern thinking of autonomy of the individual and provide the rules and regulations, so that a person has to give informed consent before medical professionals are able to perform procedures on the individual.<sup>3</sup>

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<sup>1</sup> This is clearly seen by the resurgence of cases dealing with assisted suicide which some regard as the ultimate form of autonomy i.e. being master of when one should die. A recent case of such in South African Law is *Stransham Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP).

<sup>2</sup> Beauchamp TL & Childress JF *Principles of biomedical ethics* (2001) New York: Oxford University Press. The four main principles being autonomy, beneficence, non-maleficence and distributive justice.

<sup>3</sup> See for example: The Constitution of the Republic of South Africa 1996, Section 12(2)(b). National Health Care Act 61 of 2003, sections 6 and 7. Cases such as *Castell v De Greef* [1994] 4 All SA 63 (C). All of these are referred to and examined in detail in this dissertation.

The topic of informed consent has become vast and comprehensive in South African society illustrating just how important it is and how much thought has been placed into making sure that it is adequately described at all levels. In order to fully understand all of the components that make up the doctrine of informed consent in South Africa many different areas of law and ethics must be looked at. These include not only how the law makes provisions for informed consent, but also the ethical requirements, and how informed consent is to be obtained from those who are not themselves fully autonomous, for example: children and those with mental disorders.

In order to fully deal with this topic, we will first look at the different layers of law in South Africa, specifically focusing on the parts of each that apply to informed consent. Then I will move onto the ethics of informed consent before dealing with the justifications that are available to medical professionals so that they may be able to perform procedures when patients are not able to give informed consent. Lastly, I will summarise what I have found and detail an analysis of the current position of informed consent in South Africa.

## Chapter 2

### Definition and Constitutional Basis of Informed Consent

#### Introduction

Informed consent is a complex concept and the first step in understanding the doctrine of informed consent is to get a definition of informed consent that can then be fleshed out to come to an understanding of what is encompassed in our law by the term. In this chapter we will give a definition of informed consent that we can use in the rest of this dissertation. Furthermore our understanding of the legal basis for informed consent in South Africa will be started by referring to the Constitution of the Republic of South Africa, 1996 (The Constitution) and looking at what sections pertain to the doctrine of informed consent.

#### Defining Informed Consent

In order to correctly understand the concept of informed consent it is apt to first have a clear definition of the term. According to the Cambridge Advanced Learner's Dictionary<sup>4</sup> the word "inform" is defined as: "to tell someone about particular facts"<sup>5</sup>, while consent is defined as: "to agree to do something, or to allow someone to do something". Thus it can be seen that joining these two definitions together a definition for informed consent would be "To allow someone to do something after being told particular facts".<sup>6</sup> The two main characteristics of informed consent that can be taken from this definition is that of knowledge and permission.

Thus, certain factors must be examined so that a formal understanding of informed consent can be arrived at. Firstly, what is the information that the person must be given, how must he or she be given it and what does the person need to do with it. The information given to the patient has many requirements that must be fulfilled. These requirements include the patient

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<sup>4</sup> (2005) Cambridge: Cambridge University Press.

<sup>5</sup> Ibid 655.

<sup>6</sup> Ibid 263.

being given information about the whole procedure together with how the procedure will be performed, who will be doing the procedure and what the complications of the procedure are. It is obvious that there is an abundance of knowledge that the physician has and nobody expects the doctor to educate the patient up to his level. However, what is required is that the doctor gives the patient any information that could influence a reasonable person in his position when making the decision.<sup>7</sup> Furthermore, the patient must have an understanding of this knowledge as without understanding the knowledge is ultimately useless. These requirements will be more thoroughly dealt with in Chapter 4 where it is summarised quite aptly in case law.

The second part of informed consent is the actual consent given by the patient to the doctor who will be performing the procedure. It is clear that consent is the final stage and can only be given after the patient has full knowledge and understanding of the procedure together with its potential complications.<sup>8</sup> The person who will be doing the procedure is the one who is ultimately responsible for the informed consent. Without having obtained such informed consent the healthcare provider will have committed assault for any procedure performed on the patient and may be prosecuted.<sup>9</sup> The specifics of how and by whom the consent must be given, if the patient cannot give it will be dealt with in a later chapter.

Black's Law Dictionary<sup>10</sup> gives a definition of the term "informed consent" as: "... 2. A patient's knowing choice about a medical treatment or procedure, made after a physician or other healthcare provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure. - Also termed *knowing consent*."<sup>11</sup> It can be seen that this

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<sup>7</sup> *Castell v De Greef* [1994] 4 All SA 63 (C), this case will be dealt with in detail in a later chapter.

<sup>8</sup> Van Oosten FFW. *The Doctrine of Informed Consent in Medical Law*. (unpublished LLD thesis, UNISA, 1989)

<sup>9</sup> See the argument in chapter 5 pertaining to whether the doctor has committed assault or has just been negligent as opined by some.

<sup>10</sup> Garner BA (Ed) *Black's Law Dictionary* (2009) Minnesota: West

<sup>11</sup> *Ibid* at 346

definition fits with the one laid out above. However, it should be noted that the definition lacks the term understanding. This difference must be noted as it plays an important role of what the requirements of informed consent are.

### Foundation of Informed Consent

Consent, in South Africa, operates on the basis of the doctrine: *volenti non fit injuria* (“to a willing person, injury is not done”). Van Oosten, in his foundational text, outlining informed consent stated that in South Africa for consent to be used as a defence, the following requirements must be met<sup>12</sup>:

- a. “It must be recognised by law, that is it must not be contra bonos mores.
- b. It must be given by a person capable in law of consenting, that is by someone who is capable of forming an intention (*wilsbevoeg*) or of understanding what he consents to.
- c. It must be free and voluntary, that is not induced by fear, force or fraud.
- d. The consenting party must have had knowledge and been aware of the nature and extent of the harm or risk.
- e. The consenting party must have appreciated and understood the nature and extent of the harm or risk.
- f. The consenting party must have consented to the harm or assumed the risk.
- g. It must be comprehensive, that is extend to the entire transaction, inclusive of its consequences.
- h. It must be clear and unequivocal.
- i. It must precede the conduct in question.
- j. It must be manifested externally to qualify as a legal act (*regshandeling*).
- k. It must, as a rule, be granted by the plaintiff or complainant himself.
- l. The conduct in question must fall within the limits of the consent given, that is it must not exceed the bounds of the consent given.”

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<sup>12</sup> Van Oosten FFW. *The Doctrine of Informed Consent in Medical Law*. (unpublished LLD thesis, UNISA, 1989)



The foundational nature of these criteria can be seen in the fact that they still apply in South African law. Due to the importance of informed consent in modern medicine many of these criteria have been formally stated and expounded upon in the constitution, legislation and case law.

### Informed Consent in the Constitution

The supreme law of South Africa is the Constitution of the Republic of South Africa, 1996 and when analyzing informed consent, it is pertinent to start with the Constitution. Section 1 of the Constitution states:

“1. The Republic of South Africa is one sovereign, democratic state founded on the following values:

(c) Supremacy of the constitution and the rule of law.”

When looking at informed consent it can be clearly seen that the Constitution itself specifically deals with the matter of a person needing permission, i.e. informed consent, before physically or psychologically interfering with another person.

Section 12(2)(b) of the Constitution states:

“Everyone has the right to bodily and psychological integrity, which includes the right – (b) to security in and control of their body”.

Thus it can be seen that the Constitution makes clear provision for a person to maintain their physical integrity. If any other person wishes to interfere with that integrity he or she must first have a legal way to do so. In law this is done using *volenti non fit injuria*<sup>13</sup>, where the person consents to another interfering with his/her physical integrity. This extends to the person having to give consent to anything that may interfere with his or her physical integrity.<sup>14</sup>

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<sup>13</sup> Translated as: “to a willing person, injury is not done”

<sup>14</sup> The court in *Christian Lawyers Association v Minister of Health (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T) refers to informed consent. The court stated: “The concept is ... not alien to our common law. It forms the basis of the doctrine of *volenti*

The inviolability of a person has two components. These two can be seen from the two sets of words used: “security in” and “control of”. In *The Bill of Rights Handbook* Currie I and De Waal J<sup>15</sup> state that these two terms are not synonymous. They state that “security in” refers to the protection of bodily integrity against intrusions by the state and others” while “control of” refers to the component of the right to be left alone so as to be allowed to live the life one chooses.

In determining what may or may not be an intrusion it is pertinent to consider section 12(1)(c) of the constitution which states:

“Everyone has the right to freedom and security of the person which includes the right –

(c) to be free from all forms of violence from either public or private sources; ...”

Thus it is clear that violence puts the security of a person’s body in jeopardy and is therefore against the provision. However, it is crucial to understand that subtle forms of intrusion do not necessarily always amount to a level of intrusion that warrant constitutional intervention.<sup>16</sup>

In such instances where the level of intrusion is non-trivial there may be a general application authorising the constitutional infringements of the rights. This is allowed based on Section 36: Limitation of rights.

“36. (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors...”<sup>17</sup>

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*non fit injuria* conduct that would otherwise have constituted a delict or crime if it took place without the victim’s informed consent. More particularly, day to day invasive medical treatment, which would otherwise have constituted a violation of a patient’s right to privacy and personal integrity, is justified and is lawful only because as a requirement of the law, it is performed with the patient’s Informed Consent

<sup>15</sup> Currie I, De Waal J (2014) Cape Town: Juta & Co Ltd 287

<sup>16</sup> L Tribe (1988) *American Constitutional Law* 1330 referred to by Currie I, De Waal J (2014) *The Bill of Rights Handbook* Cape Town: Juta & Co Ltd 287

<sup>17</sup> The Constitution

Section 36 is used when two or more rights come into conflict. It is used to determine the best path forward so that a decision can be made that is both “reasonable and justifiable”. The decision is based on criteria that include: the nature of the right, the importance and purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose, and further there being no less restrictive means to achieve the purpose.<sup>18</sup> However, in the absence of such a general application the intrusion will be found unconstitutional.

The Constitution furthermore states in Section 12(2)(c):

“Everyone has the right to bodily and psychological integrity, which includes the right – (c) not to be subjected to medical or scientific experiments without their informed consent.”

This provision specifically states that informed consent must be obtained from individuals on whom “experiments” are to be performed. This shows that even medical or scientific experiments that may be beneficial to a large part of the population may not supersede the individual’s right to bodily and psychological integrity. The implication of this is to show just how much autonomy of the individual is valued in our law.

It is important to note that the Constitution, in section 12(2)(a), also states:

“Everyone has the right to bodily and psychological integrity, which includes the right – (a) to make decisions concerning reproduction; ...”

This provision serves as a recognition that the power to make decisions about reproduction is a crucial aspect of control over one’s body. Furthermore it gives validity to South Africa’s liberal abortion legislation.<sup>19</sup> Section 12(2)(a) and 12(2)(b) in conjunction have been used to defend the fact that in South

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<sup>18</sup> Criteria provided for in section 36 to justify the application of the limitation of a person’s rights.

<sup>19</sup> Choice on Termination of Pregnancy Act 92 of 1996

Africa a female may get an abortion at any age regardless of whether her parents have given consent to the operation.<sup>20</sup>

Another part of the Constitution which is pertinent is section 39: Interpretation of the Bill of Rights which crucially states that:

“39 (1) When interpreting the Bill of Rights, a court, tribunal or forum –  
(b) must consider international law; and  
(c) may consider foreign law.”

In later chapters, it will be seen that case law, especially that of England, has influenced the law of informed consent as it is practiced in South Africa.

Thus it can be seen that the constitution clearly sets out the principle of informed consent and protects the right of the individual not to be interfered with without specifically giving informed consent. However, it can also be seen that the constitution sets out when this right may be broken and thus allows for grounds of justification for violating this right.

## Conclusion

Informed consent implies that the person understands what is about to happen to him or her and consents to those actions occurring. Furthermore it can be seen that the supreme law of the land, being the Constitution of the Republic of South Africa, directly deals with a person having autonomy of his own body and thus allowing for the doctrine of informed consent to have legal authority of the highest import.

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<sup>20</sup> *Christian Lawyer’s Association v Minister of Health (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T)

## Chapter 3

### Informed Consent in the Legislation

#### Introduction

The Constitution of South Africa is a jurisprudential document that is a guiding light for what law should be implemented and how it should be implemented in our society. However, it does not deal with every detail of every law. For these “details” we must turn to the legislation which governs how the principles of the constitution are implemented in the law. When dealing with the medical profession and thus informed consent as it relates to the medical profession we must look at the National Health Act 61 of 2003 (National Health Act). It is thus to this that we now turn.

Section 7 of the National Health Act clearly sets out the main obligations that are required of any healthcare service provider when obtaining informed consent from the healthcare user:

“7. Consent of user – (1) Subject to section 8, a health service may not be provided to a user without the user’s informed consent, unless –

(a) the user is unable to give informed consent and such consent is given by a person –

- I. Mandated by the user in writing to grant consent on his or her behalf;
- or
- II. Authorised to give such consent in terms of any law or court order;

(b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;

(c) the provision of a health service without informed consent is authorised in terms of any law or a court order;

- (d) failure to treat the user, or group of people which include the user, will result in a serious risk to public health; or
  - (e) 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 the user has not expressly, impliedly or by conduct refused that service.
- (2) A health care provider must take all reasonable steps to obtain the user's informed consent.
- (3) For the purposes of this section “**informed consent**” means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6.”<sup>21</sup>

It can be seen that a healthcare service provider may not provide any service without the user's consent unless some justification as detailed in section 7 subsection 1 (a) – (e) can be met. In section 7(2) it can be seen that the onus is on the healthcare provider to make sure that all reasonable avenues have been taken to obtain the informed consent of the user. Thus, a healthcare provider cannot, after the procedure is done, contend that the user should have ensured that he or she gave informed consent as it is not the user's duty.

To see what is specifically meant by consent as set out in the National Health Act, section 6 must be read:

- “6. User to have full knowledge – (1) Every health care provider must inform a user of –
- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
  - (b) the range of diagnostic procedures and treatment options generally available to the user;
  - (c) the benefits, risks, costs and consequences generally associated with each option; and

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<sup>21</sup> National Health Act 6 of 2003

(d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

(2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which considers the user's level of literacy."

It can be seen from the above section that it explicitly details exactly what information the healthcare provider needs to give to the user in order for the user to be able to give informed consent or informed refusal to the healthcare provider. Section 6 is titled "User to have full knowledge", which makes it clear that for the user to have full knowledge he or she has to be given the necessary facts as set out in the section 6. Using the above subsections, a checklist could be created for the exact items that a healthcare provider needs to give to the user. Such a checklist has been included as Appendix A.

Analysing each subsection allows for a proper understanding of what is expected.

Subsection 1 denotes the exact details that must be given to the patient.

These have been divided into various points explained below:

- (a) requires that the user be given his or her health status which means that the outcome of all tests or procedures should be provided to the patient so that the patient can have an adequate understanding of their exact circumstances. However, (a) also allows for the situation where giving the user their status could have adverse effects to the user. This then becomes subjective as the healthcare provider must decide when giving the user his or health status would cause more harm to the user.
- (b) requires that the healthcare provider supplies the user with the various diagnostic procedures and treatment options that are available to him or her. This would-be user specific depending on the user's specific condition.
- (c) requires that the healthcare provider supplies the user with information on all the benefits that may be had, all the costs that may be associated with and all the consequences that are generally associated with each option provided in subsection (b). It is important

here to note that the word “generally” is included which shows that the healthcare provider need not detail every circumstance that may play out and the costs, risks and consequences involved with each but rather should focus on the ones that generally occur.

- (d) clearly sets out the flip side of informed consent which is informed refusal. The healthcare provider must allow for the user to practice the right guaranteed by section 12(2)(b) of the Constitution and refuse to have any procedure done. However, there is a proviso here that the healthcare provider must explain to the user implications, risks and obligations of such a refusal. The word “obligation” here should be viewed as two-sided. It denotes the obligation by the patient to sign that they do not want the procedure done and places an obligation on the healthcare provider not to do the procedure on the user.

Subsection (2) states that the healthcare provider must provide the information in a language that the user understands. It is obvious that if the healthcare provider does not provide the information in a format that the patient can understand, then the patient will not be able to gain any knowledge and consequently will not be able to give informed consent. It is thus stated that not only must the correct language be used but the language must be spoken in an adequate level to account for the user’s education and IQ level. The problem with this subsection is that the words “where possible” are used which is worrying. If one cannot find a translator that can bridge the language barrier between healthcare provider and the user, then surely the user will not be able to exercise his or her constitutional right to informed consent. However due to the lack of resources section 36 of the Constitution provides for reasonableness and, by using the wording it does, the legislation provides for those situations where lack of resources does not allow for interpreters to be provided.

The above legislation is quite explicit in its wording. Yet it only talks about the term “knowledge”. Van Oosten speaks about two parts of the giving over of information pertaining to informed consent, namely: knowledge (mentioned



and detailed in the legislation) and appreciation<sup>22</sup>. The term “appreciation” does not make an appearance in the legislation. Appreciation is defined by the *Cambridge Advanced Learner’s Dictionary*<sup>23</sup> as “the act of recognizing or understanding that something is valuable, important, or as described.” The problem with only using the term “knowledge” is that knowledge and appreciation are not synonymous and knowledge of something can occur without appreciation of the same. Van Oosten states: “information as a *sine qua non* for consent relates not only to knowledge, but also to appreciation. ... information must also effect appreciation for consent to become operative. ... for lawful consent the information must not merely be received by the consenting party, but it must also be understood by him. Informing the consenting party is, therefore, no mere formality to enable him to recite without comprehending what harm or risks he consents to, but a material act to enable him to weigh and balance the pros and cons and to reach a decision on whether to undergo or refuse a medical intervention.”<sup>24</sup> Herein lies the crux of the matter. The patient is not to just be given knowledge of something but must also be able to appreciate the knowledge so as to be able to make a decision on whether to give consent or not. By not using the specific word in the legislation one could argue that in fact the mere knowledge of something is enough for consent to have been given. This is patently false as without appreciation of the information given over there is no use of the knowledge and thus the patient cannot give informed consent for the procedure. One could argue that the NHA section (6)(2)<sup>25</sup> by using the wording “in a language that the patient understands” implies that the patient has an “appreciation” of what is being said. However, this would be false because the wording by using “a” clearly shows that it is specifically speaking of the circumstances where a person that only understands, for example, Zulu

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<sup>22</sup> “As regards the relationship between information and consent, it is submitted that the informed-consent requisite for lawful medical interventions relates to **knowledge** and **appreciation** as requirements of legally effective consent.” Van Oosten FFW. *The Doctrine of Informed Consent in Medical Law*. (unpublished LLD thesis, UNISA, 1989) 20

<sup>23</sup> Colin McIntosh (Ed) (2013) Cape Town: Cambridge University Press 67

<sup>24</sup> Van Oosten FFW. *The Doctrine of Informed Consent in Medical Law*. (unpublished LLD thesis, UNISA, 1989)

<sup>25</sup> National Health Act of 1996

should be given the information in Zulu and not that the actual wording be appreciated.

## Conclusion

From this chapter, it can be seen that the doctrine of informed consent is laid out in its legal requirements in the National Health Act. It is plain to see that the Act requires that the medical professional fully informs the patient before any procedure and obtains the patient's informed consent for the procedure. The act of informing the patient requires two parts. That of knowledge and appreciation. The legislation omits the word "appreciation" which therefore leads to only the partial implementation of what the patient requires in order to give informed consent. This omission could be easily rectified by an amendment to the act in which the appreciation of knowledge is set out as a criterion for the patient to give informed consent for any procedure.

## Chapter 4

### Informed Consent in the Case Law

#### Introduction

The previous two chapters showed how the doctrine of informed consent has been provided for in the constitution and legislation. In order to find out how this was applied to the people that have brought actual cases to court and in order to see how the learned judges apply such law, we must now turn our attention to the case law. The case law is important as the courts are able to further flesh out subjects that are not dealt with in legislation.

The Constitution and legislation are applied by the courts in deciding cases and this will be clearly seen in the following cases. *Stoffberg v Elliot*<sup>26</sup> is one of the first known cases where the court dealt with the principle of informed consent. It is interesting to note that, in 1923 when the case occurred, such a principle was applied without the constitution or legislation to act as a foundation for it. The case dealt with Dr Elliot who performed an amputation of Mr. Stoffberg's penis without consent being given by the patient. Mr Stoffberg sued the Doctor for performing the amputation which he had not given informed consent for. In his judgment, Ingram CJ stated:

“every person has certain absolute rights which the law protects. They are not dependent upon statute or upon a contract, but they are rights to be respected, and of these rights is the right to absolute security of the person”.<sup>27</sup>

It can be seen that the court identified that security of a person is an absolute right to be respected and is not dependent on statute or contract. This statement occurred 73 years before the Constitution was implemented and shows how fundamental informed consent is. The judge went on to state:

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<sup>26</sup> 1923 CPD 148

<sup>27</sup> Ibid at 148

“any bodily interference with or restraint of a man’s person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to the interference.”<sup>28</sup>

Thus it can be seen that the law views such actions as wrong and allows a person to claim damages for it. This statement summarises most of the law pertaining to informed consent and thus it is important to analyse it. The Judge specifically refers to any interference of a man’s person which is not justified. This shows that a key point in the absolute security of the person is that there must be some justifications to breaking it. The Judge lists these as being justified or excused in law or consented to. This shows that without informed consent, or some law acting as the justification, a wrong would have been done to the person that the procedure was done on.

The *locus classicus* of informed consent in South Africa has been definitively recognised as the case of *Castell v De Greef*<sup>29</sup>. The case involved a plastic surgeon who performed a surgical operation on the plaintiff’s breasts. Complications occurred as the result of the procedure and the appellant claimed that she was not properly informed of the operation to be done nor would she have given consent if she would have had all the facts at her disposal regarding the complication rates of the procedure to be performed.

In his judgement, Ackermann J stated<sup>30</sup>:

“In the South African context the doctor’s duty to disclose a material risk must be seen in the contractual setting of an unimpeachable consent to the operation and its sequelae”.

The criteria for informed consent were summed up by the Judge:

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<sup>28</sup> Ibid at 149

<sup>29</sup> [1994] 4 All SA 63 (C)

<sup>30</sup> Ibid at 79

“For consent to operate as a defence the following requirements must, *inter alia*, be satisfied:

- a) The consenting party ‘must have had knowledge and been aware of the nature and extent of the harm or risk’;
- b) The consenting party ‘must have appreciated and understood the nature and extent of the harm or risk’;
- c) The consenting party ‘must have consented to the harm or assumed the risk’;
- d) The consent ‘must be comprehensive, that is extend to the entire transaction, inclusive of its consequences’. (See Van Oosten (*op cit* at 13-25 and the authorities there cited).)”<sup>31</sup>

Thus specific criteria have been laid out which will allow informed consent to have said to have been given. Firstly the user must have the knowledge of and been aware of the procedure and any risks and complications that could arise from the it. The user must also have appreciated and understood the information given. Thus it is clear that both knowledge and understanding are needed. This is in contrast to what has been seen in the legislation<sup>32</sup>, as referred to in the previous chapter, where only knowledge is specifically mentioned. Only then can the user give informed consent.

It is important to note that the informed consent that is agreed to by the user must include the entire procedure and any complications that may occur. It is easy to understand that unless the entire procedure is consented to, with its risks, then the healthcare provider will still be said to be assaulting the user when the procedure is performed and if or when any complications occur.

However on analysis of the above criteria one need ask what risks should the patient be informed of for surely if all the risks are given for every operation then the list will be of such a nature to deter the most courageous user from

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<sup>31</sup> Ibid at 80

<sup>32</sup> National Health Act 61 of 2003

entering the operating theatre. In dealing with this Ackermann refers to *Rogers v Whitaker* at 52 and quotes from the case:

“The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; 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 be 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. This duty is subject to therapeutic privilege.” Thus it can be seen that the patient should be warned of a material risk. A material risk being one that a reasonable person in the user’s position, if warned of such a risk would attach significance to or that the healthcare provider knows the user would attach significance to.

The Judge then goes on to specifically state the criteria of a material risk:

“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) 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.”<sup>33</sup>

An issue which has come up in the case law is the question of specifically how small a risk must a complication have for a doctor not to be found negligent in not making the patient aware of it. This question was dealt with in the case of *Louwrens v Oldwage*<sup>34</sup>. Mr Oldwage experienced pain in his right leg and consulted his GP who then referred him to Dr Louwrens, a vascular surgeon, for specialist treatment. Louwrens proceeded to do an angiogram on Oldwage which showed various arteries in his right upper leg that were blocked. The doctor concluded that Oldwage had severe ischaemia, which required an urgent bypass operation. The patient went for an iliac bi-femoral

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<sup>33</sup> *Castell v De Greef* [1994] 4 All SA 63 (C)

<sup>34</sup> [2006] 1 All SA 197 (SCA)

bypass. After the operation the patient had pain in the left leg and it was ultimately concluded by Professor De Villiers that Oldwage had developed “steal syndrome”, which was causing the claudication and pain in the left leg. Oldwage argued that he was not informed that there was a risk that he may develop “steal syndrome”. In determining what risks the patient must be informed about the court turned to *Castell v De Greef*.<sup>35</sup> The court focused on the requirement mentioned therein which states:

“the consent ‘must be comprehensive, that is extend to the entire transaction including of all its consequences.’”

In the case Professor De Villiers gave evidence that there was a 4% chance of such a complication occurring. Another witness, Professor Immelman, gave evidence that the study that De Villiers based his evidence on was old and not comparable to current circumstances. He argued that the risk at the time when the operation occurred would have only been 2%. Immelman further stated that: “If there was only a two per cent chance of ‘steal’ occurring then the risk to the plaintiff was so negligible that it was not unreasonable for the defendant not to mention it.”<sup>36</sup>

There was already precedent set for not having to mention every risk. Mthiyane JA referred to the case of *Richter and another v Estate Hammann* 1976 (3) SA 226 (C) at 232G-H in which Watermeyer - when deciding whether a neurosurgeon had been negligent not to warn a patient of a remote possibility of complications arising – stated:

“A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient’s interest to have it. It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and, if that is

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<sup>35</sup> [1994] 4 All SA 63 (C)

<sup>36</sup> *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA)

so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem.”

The court agreed with the evidence of the 2% risk.<sup>37</sup> It can be concluded from this that a 4% risk is a risk which could reasonably occur and the patient should be consulted about it whereas a 2% risk is too remote to have to inform the patient about it.

It is surprising that the court did not mention the criteria for the specific types of risks that should be mentioned to the patient that were set out in *Castell v De Greef*. The first criterion specifically dealt with what the reasonable doctor would tell the patient whereas the second criterion stated that if the doctor knew that the patient would think that a particular risk would be important, then the doctor should inform the patient of it. In this case Mr Oldwage could have argued that he would have found such a complication important to know and therefore the doctor should have told him about it, no matter how small the risk.

Thus it can be seen that there is a benchmark of sorts that has been set, that of a reasonable person. The medical practitioner should take note of which risk a reasonable person would want to be told of and whether the person would attach significance to that risk. Furthermore, the medical practitioner must be cognisant of each patient and also take note of what each individual patient would attach risk to. If these criteria are met then the medical practitioner has to inform the patient of such a risk in order for the patient to be said to have full knowledge. This will then allow the patient to make an informed decision and give informed consent.

## Conclusion

Thus it can be seen that the case law in South Africa has fully fleshed out what is required in terms of obtaining informed consent. The *locus classicus*

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<sup>37</sup> *Louwrens v Oldwage* [2006] 1 All SA 197 (SCA) at 209



of *Castell v De Greef*<sup>38</sup> was of major importance in the proper implementation of the doctrine of informed consent. It gave us the criteria for what is needed for informed consent and the requirements of what risks are needed to be given to the patient. Furthermore *Lourens v Oldwage*<sup>39</sup> came to show us what percentage chance a risk should have of occurring for the reasonable doctor not to need mention it to a patient. Medical practitioners thus have the clarity needed of what the requirements of them are and cannot claim otherwise. The South African legal system has therefore been comprehensively covered with respect to informed consent and implementation of the doctrine has clearly been achieved.

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<sup>38</sup> [1994] 4 All SA 63 (C)

<sup>39</sup> [2006] 1 All SA 197 (SCA)

## Chapter 5

### Punishment where no informed consent is obtained

#### Introduction

Now that it can be seen that informed consent permeates the law from the Constitution to the case law one must ask what are the consequences of not adhering to such. The question of what the failure to obtain informed consent will result in, in terms of the law, is one that is not as straightforward as may at first be thought. Some feel that it should be considered as negligence on the part of the medical personnel and should therefore require the fulfillment of the conditions of negligence. Others believe that it should be considered as wrongful and should require the fulfillment of the conditions of wrongfulness. Below, the differences between negligence and a delictual wrong will be set out and then a conclusion will be arrived at, as to which one is more appropriate to apply to informed consent.

#### Negligence

Negligence by a person can be found when “his or her conduct falls short of the standard which the law expects of the reasonable person in the particular circumstances of the case.”<sup>40</sup> To ascertain as to whether someone has been negligent we must apply the test for negligence. This was set out in *Kruger v Coetzee*<sup>41</sup> where Holmes JA stated:

“For the purposes of liability *culpa* arises if:

- a) A *diligens paterfamilias* in the position of the defendant:
  - i. Would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
  - ii. Would take reasonable steps to guard against such occurrence; and

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<sup>40</sup> Dutton I *The Practitioner’s Guide to Medical Malpractice in South African Law* (2015) Cape Town: SiberInk 85

<sup>41</sup> 1966 (2) SA 428 (A) at 430 E

b) The defendant failed to take such steps.”

Thus, it can be seen from the above criteria that there are four criteria that need to be met in order for negligence to be found. These criteria are:

1. There must be a reasonable person, or in our circumstances the test is elevated to – there must be a reasonable medical person.
2. There must have been reasonable foreseeability of what occurred.
3. There must have been reasonable preventability of the harm that occurred.
4. The negligence that would have been found using the preceding points must be judged based on the circumstances that surrounded the events that took place.

It can be seen that there are those in the legal profession that consider the omission of obtaining informed consent as negligent behaviour. This can be seen in *Wroe v McDonald*<sup>42</sup> where Erasmus J stated, when referring to failure to properly obtain informed consent: “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. ... There is, therefore, no direct causal link between the defendant’s negligence (in failing to warn the plaintiff of the risk) and the occurrence of the harm, unless it is shown that the plaintiff, upon being warned of the risk, would not have undergone the procedure at all. ...”

Strauss in *Doctor, Patient and the Law* refers to the case of *Richter and Another v Estate Hamman*<sup>43</sup> where Watermeyer J stated:

“It may well be that in certain circumstances a doctor is negligent if he fails to warn a patient, and if that is so, it seems to me in principle that his conduct should be tested by the standard of the reasonable doctor faced with the particular problem.”

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<sup>42</sup> [2011] JOL 27933 (C) at 20

<sup>43</sup> 1976 (3) SA 226 (C)

Strauss further refers to an English case of *Chatterton v Gerson and Another*<sup>44</sup> where the facts of the case were similar to the *Richter* case. The court found, in reference to the negligence claim, that the plaintiff would have to prove that not only did the doctor fail to inform but also that if the doctor had not failed to inform the patient, then the patient would have chosen a different course of action. Thus, Strauss concludes that: “The court intimated – obiter, it would seem – that a failure to go into risks and implications is negligence.” Lastly, Strauss refers to American Law and states that there to as well there is case law where support is given to the failure to obtain informed consent as being negligent.<sup>45</sup>

It would therefore seem from the South African, English and American case law presented that we should accept that failure to obtain informed consent should be considered as negligence. However, Strauss concludes that: “I would submit that these precedents and the ruling in *Chatterton’s* case should not be followed by our courts.

The criteria mentioned above in the case law for how informed consent should be dealt with raises a few issues which seem untenable:

1. A doctor cannot be punished for failing to obtain informed consent unless he acted negligently in the procedure that followed.
2. The patient must prove that he or she would not have undergone the operation if the risks were known.
3. That failure to inform the patient is a form of negligence.

As has been stated in previous chapters the right to bodily integrity is a constitutional right.<sup>46</sup> From this flows the laws pertaining to informed consent.<sup>47</sup> It cannot be justifiable that a doctor or any other medical personnel can be punished only if he or she acted negligently. Surely the mere act of not

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<sup>44</sup> [1981] 1 QB 432

<sup>45</sup> Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (1980) Pretoria: J.L. van Schaik 268

<sup>46</sup> The Constitution, section 12(2)(b)

<sup>47</sup> Refer to chapter 2 where the legislature pertaining to informed consent are set out in full.

obtaining informed consent results in the doctor assaulting the patient. The only legal basis for physically disturbing another person is informed consent and if that is not present then it must be *prima facie* evidence that the patient has been assaulted. Furthermore, this cannot be an act of negligence because negligence, as stated above, involves foreseeability and preventability. In a case where informed consent was not obtained the doctor did not fail to foresee that he would be doing surgery on the patient. He did the surgery intentionally. This would make the act wrongful.

This then brings us to the opinion of those that believe that failure to obtain informed consent should be seen as a wrongful/unlawful action.

### Wrongfulness/Unlawfulness

The test to ascertain as to the wrongfulness(unlawfulness) of an act has been set out in the case of *Minister van Polisie v Ewels*<sup>48</sup> where it was stated: “Our law has developed to the stage where an omission is regarded as unlawful conduct when the circumstances of the case are of such a nature that the omission not only incites moral indignation but also that the legal convictions of the community demand that the omission ought to be regarded as unlawful and that the damage suffered ought be made good by the person who neglected to do a positive act. In order to determine whether there is unlawfulness the question, in a given case of an omission, is thus not whether there was the usual “negligence” of the *bonus paterfamilias* but whether, regard being had to all the facts, there was a duty in law to act reasonably”. The act of informed consent is one prescribed by law and one where the omission can be seen, in this day and age, to go against the principle of patient autonomy and the *boni mores*.

From this it can be seen that the criteria are fulfilled to regard the omission of obtaining informed consent as a wrongful act. It is necessary to show from the literature support for this claim. It should be noted that many authorities

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<sup>48</sup> 1975 (3) SA 590 (A) at 597

instead of only focusing of the wrongfulness of the act rather talk about the act being of the nature of assault. It will be seen that in order for a case of assault to be brought it would necessitate that the act is unlawful/wrongful.

### The criminal case

As has been stated previously, modern society has moved from a state of paternalism of the patient to one of patient autonomy. The constitution makes this a fundamental right when it guarantees, in section 12(2)(b), a person's psychological and physical integrity over their own body. The way in which medical professionals usually overcome this right is to obtain informed consent from the patient. Therefore, if the medical professional did not obtain informed consent from the patient would he be guilty of assaulting the patient?

To answer this question, it is important to refer to the definition of assault. The *Principles of Criminal Law*<sup>49</sup> states:

“Assault consists in unlawfully and intentionally (1) applying force to the person of another, or (2) inspiring a belief in that other person that force is immediately to be applied to him or her.”<sup>50</sup>

It can be seen from this definition that “assault” consists of two parts, namely unlawfulness and intentionality. The topic of unlawfulness was dealt with above in the previous section. Here we shall deal with intentionality. The *Principles of Criminal Law*<sup>51</sup> states that: “An intention to assault (in the sense of actual or legal intention (i.e. *dolus eventualis*) must be proved. If only negligence (even gross negligence) exists, the fault for common assault is lacking.”<sup>52</sup> Thus the plaintiff must show that the medical professional intentionally did not obtain informed consent. The basis on which the plaintiff will have to prove such intentionality will be much higher as the standards for a criminal charge require that it is beyond a reasonable doubt that such actually occurred.

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<sup>49</sup> Burchell J (2014) Cape Town: Juta and Company.

<sup>50</sup> Ibid at 577

<sup>51</sup> Ibid

<sup>52</sup> Ibid at 585

A case in which the charge of assault for failing to obtain informed consent was brought up was *Richter and Another v Estate Hammann*<sup>53</sup>. The case dealt with a young married woman who had fallen on the sharp edge of a chair and had thereby injured her coccyx a second time. The neuro-surgeon who treated performed a phenol block, a type of injection, of the lower sacral nerves which resulted in the loss of bladder and bowel control, loss of sexual feeling and loss of power in the right leg and foot. The plaintiff alleged that the doctor had acted negligently in failing to warn her of the possibility of these complications ensuing from the injection.

In his judgement, Watermeyer J, when speaking about the complications that a doctor must tell the patient stated: “If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into having the operation when the doctor knows full well that it would be in the patient’s interests to have it.”<sup>54</sup>

Strauss in *Doctor, Patient and the Law*<sup>55</sup> referred to *Richter and Another v Estate Hammann*<sup>56</sup>. He stated that the court did not decide that failure of the doctor to adequately inform the patient of the consequences would equate to negligence of the doctor. Furthermore, in connection with the charge of assault he stated that:

“Traditionally our courts have dealt with non-compliance of doctors with the duty to obtain an informed consent on the basis of assault. It is submitted that to consider failure to inform as negligence would not be in accordance with the Roman-Dutch concept of *culpa* which until now has been defined as the failure to foresee the damaging consequences and to take reasonable measures to avoid it. The essence of negligence in the medical context is unskillful treatment.”<sup>57</sup>

Strauss goes on to refer to South African, American and English case law in which the judges were of the view that failure to inform a patient adequately is

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<sup>53</sup> 1976 (3) SA 226 (C)

<sup>54</sup> *Ibid* at 504

<sup>55</sup> Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (1980) Pretoria: J.L. van Schaik 268

<sup>56</sup> 1976 (3) SA 226 (C)

<sup>57</sup> Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (1980) Pretoria: J.L. van Schaik 268

tantamount to negligence.<sup>58</sup> However he concludes that: “I would submit that these precedents and the ruling in *Chatterton’s* case should not be followed by our courts. Where there has been no consent in fact given was so ‘uninformed’ as to the nature of the procedure or consequences thereof that may well manifest themselves, that it cannot be said that there was a ‘real’ consent – the patient will have an action based upon assault.”<sup>59</sup>

It is thus clear that one of the foremost thinkers of medical law in South Africa opined that the failure to obtain informed consent should not be considered negligence and should be dealt with as assault by the doctor. Strauss clearly viewed the act of not obtaining informed consent as wrongful and not negligent.

Strauss’ view is also accepted by Professor Carstens in *Foundational Principles of South African Medical Law*<sup>60</sup> where he refers to the case of *Castell v De Greef*<sup>61</sup>. This case is very influential as it was a decision of the full bench of the Cape Provincial Division. In this case the court found that a physician’s failure to adequately inform a patient constitutes assault and not negligence. Carstens quotes the opinion of Van Oosten who wrote: “[T]he court’s preference to place the doctor’s duty of disclosure and its concomitant, the patient’s informed consent within the framework of the wrongfulness element ... rather than the fault element ... of delict. This is certainly correct where a medical intervention has been performed without the patient’s informed consent, but with due care and skill and has proved to be beneficial to the patient’s health: Here the appropriate action would be assault or *iniuria*, as the case may be, rather than negligence.”<sup>62</sup>

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<sup>58</sup> *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C); *Chatterton v Gerson and Another* [1981] 1 QB 432

<sup>59</sup> Strauss SA *Doctor, Patient and the Law: A Selection of Practical Issues* (1980) Pretoria: J.L. van Schaik 268

<sup>60</sup> Carstens P, Piermain D (2007) LexisNexis: Durban

<sup>61</sup> [1994] 4 All SA 63 (C)

<sup>62</sup> *Foundational Principles of South African Medical Law* Carstens P, Piermain D (2007) Durban: LexisNexis 681



From here it can be seen that Van Oosten has noted that an act that is beneficial to the patient cannot be viewed as being negligent. Furthermore, just because the doctor acted with due care and skill, i.e. performed the operation without negligence does not mean that the failure to obtain informed consent does not play a part. The act being wrongful causes these criteria to fall away and the fact that informed consent becomes the wrongful act that must be answered to by the medical professional.

The case of *Broude v McIntosh*<sup>63</sup> needs to also be taken into account. The case is influential as it eventually came before the Supreme Court of Appeal. Briefly, the case deals with a Dr Broude who was operated by Dr McIntosh, an ENT. The operation done was a cochlear vestibular neurectomy. The operation involves the severing of the cochlear and vestibular nerves. After the operation the appellant showed signs of complications. The appellant then brought an action for damages alleging that the respondent had wrongfully failed to obtain the appellant's real or informed consent to the operation and the respondent accordingly had committed an assault on the appellant in operating on him.<sup>64</sup> In his judgement, Marais JA expressed<sup>65</sup> his reservation about such an approach being used. He intimated that a doctor is there to help the patient and therefore to claim that the doctor assaulted the patient merely because certain risks were not stated and may have resulted in a different course of action to be unsound. It should be noted that the Judge stated this in his *obiter dicta* and therefore did not overrule the decision of *Castell v De Greef* (1994).

The problem with this line of thinking is that the judge appears to have wrongly understood what the assault is based on. The assault that is being implied is because the patient was operated on without proper informed consent being obtained. Therefore, it has in effect nothing to do with the results of the operation but the fact that the operation was carried out at all. As has been stated above, the individual has autonomy which cannot be

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<sup>63</sup> [1998] 2 All SA 555 (A)

<sup>64</sup> *Ibid* at 556

<sup>65</sup> *Ibid* at 562 and 563

intruded upon without informed consent. Following this line of reasoning the Judge erred in his *obiter dicta*.

*Foundational Principles of South African Medical Law*<sup>66</sup> refers to an unreported case of *Pop v Revelas* in the Witwatersrand Local Division of the High Court of South Africa. The main point of the case was that the patient underwent a procedure which he said that he did not give informed consent for. The court found that the doctor indeed had performed an operation on the patient without any informed consent and thus was liable. The court determined that since no informed consent had been given the doctor had unlawfully invaded the physical integrity of the patient, even if that was skillfully done. It is clear from this case that it was the patient's autonomy that had been compromised without informed consent and therefore it was of no consequence how the operation was performed. What mattered was that an assault on the patient had effectively been committed.

A more recent case that deals with the issue of lack of informed consent resulting in assault is that of *Oldwage v Louwrens*<sup>67</sup>, which was heard in the Cape Provincial Division of the High Court. In his judgement, Yekiso J held that he was bound by *Castell v De Greef* and therefore found that the defendant's conduct, as it did not constitute properly informed consent, constituted assault. This is clearly in keeping with the literature and case law that has come before.

However, the case was taken on appeal in *Louwrens v Oldwage*<sup>68</sup>. The court stated in its judgement that it would specifically address the ground of appeal i.e. that there was an absence of consent and whether that constituted an assault.<sup>69</sup> However in the section specifically entitled "Was there informed consent?" the question is never answered. The court merely states that there is insufficient evidence to show that informed consent was not obtained and

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<sup>66</sup> Carstens P, Piermain D (2007) Durban: LexisNexis 682

<sup>67</sup> [2004] 1 All SA 532. The facts of the case are laid out in chapter 4.

<sup>68</sup> [2006] 1 All SA 197

<sup>69</sup> *Ibid* at 207 - 209

that the defendant's omission was not negligent. Furthermore, it must be noted that the court never referred to *Broude v McIntosh* and thus it cannot be said to concur with the obiter dicta stated there (referred to above). The problem lies in the fact that the court uses both *Castell v De Greef* and *Richter v Hammann* to come to its conclusion. However as can be seen from above, the two are mutually exclusive in that the one argues that failure to obtain informed consent constitutes assault while the other states that it constitutes neglect. The one therefore stands for patient autonomy while the other stands for medical paternalism. It is impossible for the two views to be combined and thus the remarks on this part of the judgement by Carstens<sup>70</sup>, "the judgement of the Supreme Court of Appeal is ambivalent, confusing, and contentious, specifically in view of previous legal opinion and case law", is quite apt. The case could be used to argue that the Court agrees that failure to obtain informed consent results in negligence is dangerous as no such finding was actually stated by the court. It should thus be concluded that the court did not reject or overrule *Castell v De Greef* (1994).

An even more recent case of *McDonald v Wroe*<sup>71</sup> dealt with a doctor who failed to inform a patient of a potential complication of permanent nerve damage, which could occur from a dental procedure. The complication occurred as a result of the procedure. The court found that since the doctor did not inform the patient of the complication, he had not obtained informed consent and thus had violated the plaintiff's right to bodily integrity.

It can be noted from the above analysis of the literature and cases relating to informed consent that the failure to obtain informed consent before performing a procedure causes that procedure to become an assault on the patient. In order to deal with such an assault there are two ways in which the patient could seek justice. The criteria of the delictual claim is set out briefly below.

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<sup>70</sup> *Foundational Principles of South African Medical Law* Carstens P, Piermain D (2007) Durban: LexisNexis 683

<sup>71</sup> [2006] 3 All SA 565 (C)

## The Delictual Claim

The criteria for a delict are well known and set out below:

- The act
- Wrongfulness thereof
- Fault
- Causation
- Damage

**The act:** the act we are looking at is when medical personnel fails to obtain informed consent from a patient before a procedure is to be done.

**Wrongfulness:** as can be seen above, failure to obtain informed consent has been accepted by the literature as being wrongful/unlawful.

**Fault:** the medical personnel who conducts the procedure must be the one who ultimately bears the fault as it is he or she who does the procedure.

**Causation**<sup>72</sup>: it is easily seen that the medical personnel's failure to obtain informed consent resulted in the patient being assaulted as permission was not given for the procedure.

**Damage:** it must be shown that "the plaintiff, upon being warned of the risk, would not have undergone the procedure at all."<sup>73</sup>

A delictual claim would be followed by the plaintiff in order to recover damages from the medical professionals. This claim could be instituted at the same time as a criminal claim is brought against the medical professionals involved.

## Informed Consent and the doctor-patient contract

In the dealings between two parties a contract is created where promises are made as to what the rights and the obligations of both the parties will be. In the healthcare context, such contracts also exist. These may be between

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<sup>72</sup> The test for causation can be stated simply as: "the wrongdoer can only be delictually liable if his or her conduct caused the harm in question"

<sup>73</sup> Stated by Erasmus J in *Wroe v McDonald* [2011] JOL 27933 (C)

doctor and patient, hospital and patient or medical aid and hospital/medical doctor.<sup>74</sup>

Informed consent is important in relation to contracts as it is part of the consensus that must be reached before the contract can be made. Informed consent may be not only part of the consensus but also part of the terms of the contract itself. It is trite to say that for a contract to arise; all parties must have an intention to contract. The intention must arise from the free will of the parties in the context in which the contract is to be concluded. Therefore, the parties must be aware of all specifics to decide to be bound by the contract. Such is called a “consensus” or in layman’s terms a “meeting of the minds”. If misrepresentations were made that led to the contract being formed the consent that was given can be vitiated and the contract invalidated. The doctor and patient are on two different planes of knowledge and it is incumbent on the doctor to elevate the patient for the patient to have the required knowledge and appreciation to effectively consent and contract with the doctor. Any compromise in such will lead to a compromise in the contract.

In the context of healthcare, a doctor may hold back certain information from patients by claiming therapeutic privilege. This leads to an omission of some of the facts from being given to the patient, which in turn could invalidate a contract.<sup>75</sup> The omission of which facts to omit is decided by the healthcare professional and is paternalistic in nature. In the modern medical landscape patient autonomy is advanced as one of the fundamental principles.<sup>76</sup> By allowing for therapeutic privilege it gives the healthcare professional the power to determine what is in the best interests of one of the contracting parties by another contracting party. In the private sector, which is a for-profit endeavor, this power could lead to doctors intentionally leaving out certain facts so that the patient will be more willing to contract. This position is untenable and validates the strict criteria which are outlined in *Castell v De*

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<sup>74</sup> Carstens P, Piermain D *Foundational Principles of South African Medical Law* (2007) Durban: LexisNexis 308-315

<sup>75</sup> *Supra* at 314

<sup>76</sup> Beuchamp TL & Childress JF *Principles of biomedical ethics* (2001) New York: Oxford University Press

*Greef*<sup>77</sup> as to what exactly needs to be told to the patient and what risks may be left out.

The failure to obtain informed consent from the patient can result in the contract between the healthcare provider and the patient being invalidated. This will in turn result in the patient being able to claim that there was no valid contract and to refuse to pay the healthcare provider for services rendered. Informed consent can ensure that consensus is reached and thus will cause the parties to be bound by the terms of their agreement.<sup>78</sup>

## Conclusion

In this chapter, it has been argued that failure to obtain informed consent should not be viewed as negligence but should rather be viewed as wrongful. It can be seen from the law, literature and cases that lack of informed consent amounts to assault and not negligence.<sup>79</sup> The concept of assault in these circumstances should not be assessed on its strict literal sense, but rather as a violation of the patient's right to bodily integrity as entrenched in section 12(2)(b) of the constitution. The consequence of such is that the medical professional will face criminal and delictual liability should a lack of informed consent be proved in court. Finally, it has been shown that lack of informed consent can invalidate a contract between the doctor and patient thus preventing the doctor from obtaining any fees for the procedure that he has performed.

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<sup>77</sup> [1994] 4 All SA 63

<sup>78</sup> *Supra* at 322

<sup>79</sup> Carstens P, Piermain D *Foundational Principles of South African Medical Law* (2007) Durban: LexisNexis

## Chapter 6

### Informed consent relating to children

#### Introduction

Children are one of the most vulnerable members of society and therefore it is incumbent upon us to take special precautions to protect them from harm. Thus, it is only appropriate that a specific section deals with children in the constitution and legislation specifically deals with children. Children may not be able to fully understand the implications of giving consent to procedures. Furthermore, they may not be able to even understand what they are consenting to, which necessarily implies that they would be unable to give informed consent. In order to protect children, while still allowing them to undergo such procedures, the law details who may consent for them. It is essential to understand who may consent for the child, when they may consent and at what age the child may consent for him or herself, depending on the procedure involved. This chapter deals with this subject.

It can be seen, starting with the supreme law of the land which is the Constitution, that a section is devoted to the rights of the child. The section in question is section 28 which is appropriately titled “Children”. In connection with healthcare it states:

“28 (1) Every child has the right –

(a) ...

(b) ...

(c) to basic nutrition, shelter, basic health care services and social services;

(d)...

...”

We see from this that every child has the right to basic health care services in addition to the health services afforded to everyone else in society. However, because of the vulnerability of the child the section goes on to state:

“(2) A child’s best interests are of paramount importance in every matter concerning the child.”

Thus it can be seen that even when others may make decisions for the child it is paramount to take into account what is in the best interests of the child and not what may be more expedient for the parents or guardians of the child.

It is important to ascertain the age of the person that we are talking about when talking about children and this is set out explicitly in the Constitution<sup>80</sup> in this section<sup>81</sup>:

“(3) In this section “child” means a person under the age of 18 years.”

Thus having dealt with the Constitution and how it pertains to healthcare of children we have laid out that the child is someone of the age younger than 18 and that the interests of the child must take precedence. Below we will see how this is translated in legislation into the specific way that informed consent must be given for a child who may not have the capacity to be able to give informed consent.

## **Legislation**

The legislation dealing with children is set out in the Children’s Act No 38 of 2005. Thus, it is to this piece of legislation that we now turn.

The act specifically deals with what “the best interests of the child” refers to. In section 7 titled “Best interests of the child standard” it states:

“(1) Whenever a provision of this Act requires the best interests of the child standard to be applied, the following factors must be taken into consideration where relevant, namely –

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<sup>80</sup> Ibid

<sup>81</sup> Ibid, section 28



...

(g) the child's –

- (i) age, maturity and stage of development;
- (ii) gender;
- (iii) background; and
- (iv) any other relevant characteristics of the child;

...

(l) the need to protect the child from any physical or psychological harm that may be caused by:

- (i) subjecting the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person;

...”

It can be seen from this that the best interests of the child must be taken into account with respect to each individual child and his or her specific circumstances. Furthermore, any decision taken on behalf of the child must be in the best interests of the child in order to protect the child from physical or psychological harm.

Furthermore, the act has a specific section which details the importance of the best interests of the child. Section 9<sup>82</sup>: Best interests of the Child Paramount states:

“In all matters concerning the care, protection and well-being of a child the standard that the child's best interest is of paramount importance, must be applied.”

In respect of the actual consent that must be given when a child is to undergo a procedure one must look at section 129: Consent to medical treatment and surgical operation<sup>83</sup>. It states:

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<sup>82</sup> Children's Act No 38 of 2005

<sup>83</sup> Ibid

- 1) “Subject to section 5 (2) of the Choice of Pregnancy Act, 1996 (Act No 92 of 1996), a child may be subjected to medical treatment or a surgical operation only if consent for such treatment or operation has been given in terms of either subsection (2), (3), (4), (5), (6) or (7).
- 2) A child may consent to his or her own medical treatment or to the medical treatment of his or her child if –
  - a) The child is over the age of 12 years; and
  - b) The child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.
- 3) A child may consent to the performance of a surgical operation on him or her or his or her child if –
  - a) The child is over the age of 12 years; and
  - b) The child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
  - c) The child is duly assisted by his or her parent or guardian.
- 4) The parent, guardian or care-giver of a child may, subject to section 31<sup>84</sup>, consent to the medical treatment of the child if the child is –
  - a) Under the age of 12 years; or
  - b) Over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.
- 5) The parent or guardian of a child may, subject to section 31, consent to a surgical operation on the child if the child is –
  - a) Under the age of 12 years; or
  - b) Over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the operation.
- 6) The superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or a surgical operation on a child if –

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<sup>84</sup> Ibid, Section 31: Major decisions involving the child

- a) The treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and
  - b) The need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required.
- 7) The Minister may consent to the medical treatment of or surgical operation on a child if the parent or guardian of the child –
- a) Unreasonably refuses to give consent or to assist the child in giving consent;
  - b) Is incapable of giving consent or of assisting the child in giving consent;
  - c) Cannot readily be traced; or
  - d) Is deceased.
- 8) The Minister may consent to the medical treatment of or surgical operation on a child if the child unreasonably refuses to give consent.
- 9) A High Court or children’s court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent.
- 10) No parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsection (4) and (5) by reason only of religious or other beliefs, unless the parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.”

As can be seen, Section 129<sup>85</sup> is lengthy and deals with many aspects of consent relating to children and thus it is important to pick it apart so that we can properly understand what the regulations require.

- Subsection 2 deals with the child consenting to his or her own medical treatment or to the treatment of his or her own child. It states that the child must both be over the age of 12 years old and that the child is of sufficient maturity to be able to make such a decision. This therefore

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<sup>85</sup> Children’s Act No 38 of 2005

allows for some subjectivity as it allows for the medical personnel to be able to assess whether the child in fact is of the maturity and intellectual capacity needed to be able to make what could be a life-changing decision. The child needs to be able to understand all the parts of the procedure in the same way that an adult would have to in order to give informed consent.

- Subsection 3 specifically deals with a surgical operation and allows a child over 12 with sufficient maturity and mental capacity to give consent with one caveat. The child must be assisted in giving this informed consent by his parent or guardian.
- Subsection 4 states that if the child is in need of medical treatment then the guardian, parent or care-giver has the power to give consent on behalf of the child if the child is younger than 12 years old or is over 12 years old but does not maturity or is unable to understand the benefits, risks and implications of the treatment. One must note that this should only be done after listening and taking in to account any views expressed by the child.
- Subsection 5 states the same as section 5 but deals with a surgical operation.
- Subsection 6 deals with an emergency which is life-threatening or may leave the child with a permanent injury. In such cases this subsection gives the superintendent of the hospital or the person in charge the power to give consent for a medical or surgical procedure for the child without first having to try obtain consent of the legal guardian of the child.
- Subsection 7 gives the Minister the power to give consent for the child to undergo a medical or surgical procedure when the child's legal guardian unreasonably refuses to give such consent or refuses to give consent altogether, the guardian is unable to give consent (due to not having the capacity to give consent due to for example a mental disorder), cannot be traced or is deceased.
- Subsection 8 gives the Minister the power to give consent for the child to undergo a medical procedure or surgical procedure if the child

unreasonably refuses to give consent. This is only with respect to subsections 2 or 3 where the child would be over 12 years old and thus would be able to give consent for him or herself.

- Subsection 9 refers to the case where anyone who has the power to give consent for the child to undergo a medical or surgical operation unreasonably refuses to do so and empowers the High Court or a Children's court to override the decision and give consent.
- Subsection 10 makes it illegal for a legal guardian to refuse to give consent for a procedure to be done on the child if the only reason for the refusal is religious or some such other belief unless the guardian can show that there is a medically accepted alternative procedure that can be done.

It can be seen from the above subsections that even in cases where the child has the power to give consent, they do not ultimately have the final say in the matter. This is because if any of their decisions are objectively viewed as flawed then the medical personnel can have the legal guardian, or if the guardian does not consent, have the courts overrule the child's and the guardian's decision. This is because of section 9 of the act which must always be taken into account and takes the child's health to be of the utmost importance, even allowing for the overriding of the legal guardian's wishes.

#### *Can a child consent to an Abortion?*

The South African Constitution in section 12(2)(a) states that: "Everyone has the right to bodily and psychological integrity, which includes the right (a) to make decisions concerning reproduction." From the legislation referred to previously in this section it can be seen that in most circumstances a child may not give consent or may only give consent with parental assistance. However, this is not universally applicable. Abortions in South Africa are governed by the Choice on Termination of Pregnancy Act 92 of 1996.

The act specifically deals with the consent of the pregnant female to an abortion in section 5 of the act titled “Consent”. Section 5 immediately starts by recognizing that consent is needed from the patient. It states:

“5. (1)... the termination of a pregnancy may only take place with the informed consent of the pregnant woman.” Furthermore, it goes on to state that: “(2) ... no consent other than that of the pregnant woman shall be required for the termination of pregnancy.” This entrenches the constitutional right of the female to her reproductive rights. The pregnant woman alone has the right to decide on her pregnancy.

Thus, a pregnant woman needs to give informed consent. But what if that woman is under 18 and therefore is a minor? It can be seen that it is the pregnant woman’s decision alone. But a minor is said not to have the cognitive ability to decide on medical operations alone and therefore one may think that in such circumstances a parent or guardian would have to at least assist the minor in giving consent for an abortion.

In this respect the act states:

“5(3) 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.”<sup>86</sup>

Thus it can be seen that with something as important as the life of an unborn infant the minor alone has the power to consent to such an operation. It should also be noted that the termination of pregnancy usually involves a surgical procedure. Therefore, it should be noted that in this instance the minor can consent to such a surgical procedure at any age. In the case of *Christian Lawyers Association v Minister of Health (Reproductive Health Alliances as Amicus Curiae)* 2005 (1) SA 509 (T) the case was specifically put to the court that a person under 18 does not have the ability to give informed consent and therefore should not be allowed to undergo an abortion. In a well reasoned judgement the court found that the act specifically referred to the capacity of each individual to give informed consent and did not fix it to an

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<sup>86</sup> Choice on Termination of Pregnancy Act 92 of 1996

arbitrary age. Therefore, in each case of abortion, the medical practitioner must decide whether, based on the emotional and intellectual maturity of the individual concerned, an abortion can be consented to by the individual. The court further stated that if a medical practitioner or registered midwife were to still do such a procedure where such capacity has not been found, whether it be on a minor or an adult, the he or she will have done so without informed consent. The conduct will not be in accordance with the Act and will therefore be unlawful.<sup>87</sup> Such reasoning should by the court should be praised for its forward thinking with regard to age being an arbitrary number. However, the fact that the medical professional still decides on the emotional and intellectual capacity of the patient still holds a paternalistic view of the doctor patient relationship.

## Conclusion

In South African Law the health and safety of the child is of critical import. From the above sections, we can see that the parents of the child are given the task of protecting the child. They must decide for the child what procedures may or may not be needed and give informed consent for such. However, it must be noted that because the child's health is viewed so importantly, if the parents attempt to make a decision that could endanger the child, the medical practitioner may approach the courts to override the parents' decision.

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<sup>87</sup> *Christian Lawyers Association v Minister of Health (Reproductive Health Alliances as Amicus Curiae)* 2005 (1) SA 509 (T) at 1094

## Chapter 7

### Informed consent relating to Mental Health

#### Introduction

One of society's most vulnerable members are those with a mental illness<sup>88</sup>. It is obvious that when a person is in a state where they cannot comprehend the outside world, they will not be able to have the understanding to give informed consent. It is because of this that other family members and medical practitioners must step in to help these people make choices about the healthcare that they may need. There are strict rules of informed consent that apply for such patients that are specifically set out in the Mental Health Care Act 17 of 2002.

Chapter 9 of the Act<sup>89</sup> specifically deals with “consent to care, treatment and rehabilitation services and admission to health establishments.” It states:

“(1) A health care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if –

- a) the user has consented to the care, treatment and rehabilitation services or to admission;
- b) authorised by a court order or a Review Board; or
- c) due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the –
  - i. death or irreversible harm to the health of the user;
  - ii. user inflicting serious harm to himself or herself or others; or
  - iii. user causing serious damage to or loss of property belonging to him or her or others.”

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<sup>88</sup> Defined in the Mental Health Act 17 of 2002 as: “a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis.”

<sup>89</sup> Mental Health Act 17 of 2002



Thus it can be seen that with regards to a mentally ill person in certain circumstances the person may not be able to consent to his or her own treatment and thus will be admitted without his or her consent. Such circumstances are very serious as can be seen by the wording used in the act and to negate any abuse of this power strict measures have been placed to review such decisions. These can be found in section 2 of chapter 9<sup>90</sup>:

(2) Any person or health establishment that provides care, treatment and rehabilitation services to a mental health care user or admits the user in circumstances referred to in subsection (1)(c) –

- a) must report this fact in writing in the prescribed manner to the relevant Review Board; and
- b) may not continue to provide care, treatment and rehabilitation services to the user concerned for longer than 24-hours unless an application in terms of Chapter V is made within the 24-hour period.”

With regards to mental health care users there are different types. These are the voluntary, assisted and involuntary mental health care user. Due to the differences in capacity of these patients it is necessary to go through the different types of informed consent applicable to each one.

### **Voluntary user**

This user is able and willing to get treatment for his or her mental disorder and consents to such treatment.

### **Assisted user**

This user is “incapable of making informed decisions due to their mental health status and who do[es] not refuse the health interventions”.<sup>91</sup> Thus this user does not have the capacity to give informed consent due to their mental disorder have deemed them so and thus must be assisted by someone else. The ability for someone else to give consent on behalf of the user is set out in

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<sup>90</sup> Ibid

<sup>91</sup> Mental Health Care Act 17 of 2002, 5

the Act.<sup>92</sup> It states in section 1 of chapter 27: Application for assisted care, treatment and rehabilitation services<sup>93</sup>:

- “(1) (a) An application referred to in section 26 may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user, but where the –
- i. user is below the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user; or
  - ii. spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or not available to make such an application, the application may be made by a health care provider.
- (b) The applicants referred to in paragraph (a) must have seen the mental health care user within seven days before making the application.”

Thus it can be seen that when the mental health care user cannot give informed consent, informed consent can be given for him by a person set out above. It is clear that such circumstances are not taken lightly by the legislation and thus it includes subsection b which explicitly details that the person giving informed consent must have been with the user in the last seven days. This would be to prevent such informed consent for mental health care from being given by people who may not have seen the user for a long period and thus have no idea as to his or her actual mental status or whether some nefarious action is taking place.

Once the patient has been treated it is possible that he or she will recover the capacity to give consent for his or her own treatment and thus it is incumbent on the health personnel to see to it that such person has the choice to make such an informed decision at the earliest possible chance after having regained this capacity. Section 31 of the Mental Health Care Act states:

- “(1) If the head of the health establishment, at any stage after approving an application for assisted care, treatment and rehabilitation services, has

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<sup>92</sup> Mental Health Care Act 17 of 2002

<sup>93</sup> Ibid

reason to believe from personal observation, from information obtained or on receipt of representations by the user that an assisted mental health care user has recovered the capacity to make informed decisions, he or she must enquire from the user whether the user is willing to voluntarily continue with care, treatment and rehabilitation services.

- (2) If the assisted mental health care user consents to further care, treatment and rehabilitation services, section 25 applies.<sup>94</sup>
- (3) If the assisted mental health care user is unwilling to continue with care, treatment and rehabilitation services, and the head of the health establishment is satisfied that the user is –
  - a) no longer suffering from the mental illness or mental disability referred to in section 26(b), the head of the health establishment concerned must immediately cause the user to be discharged according to accepted clinical practices; or
  - b) still suffering from mental illness or mental disability referred to in section 26(b), the head of the health establishment concerned must, in writing, inform the –
    - i. person who made the application in terms of section 27; and
    - ii. mental health care practitioner, registered social worker or nurse administering care, treatment and rehabilitation services to that mental health care user.
- (4) The head of the health establishment must advise the persons referred to in subsection (3)(b) that they may make an application within 30 days of receipt of such report to the head of the relevant health establishment to provide involuntary care, treatment and rehabilitation services to the user and that section 32 and 33 apply.

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<sup>94</sup> Section 25 of the Mental Health Care Act 17 of 2002 deals with voluntary mental health care users and thus the person would become a voluntary patient.

- (5) If the application is not made within 30 days, the assisted mental health care user must be discharged.”

From here it can be seen that once the person has regained his capacity, he must be given the choice of whether to carry on with treatment and if he does not give his consent then an application must be made out to have him admitted as an involuntary mental health care user. It is important to note here that a mental disorder does not automatically preclude a person from being able to give informed consent. It is necessary for the medical practitioners to evaluate the person’s level of functioning when he or she is brought in and to determine whether the person is able to give proper informed consent or perhaps informed refusal based on that level of functioning.

### **Involuntary user**

If the mental health care user does not give his or her consent to be treated, then the patient would have to be admitted as an involuntary user. The circumstances where this is justified is detailed in section 32<sup>95</sup> - Care treatment and rehabilitation of mental health care users without consent:

“A mental health care user must be provided with care, treatment and rehabilitation services without his or her consent at a health establishment on an outpatient or inpatient basis if –

- a) an application in writing is made to the head of the health establishment concerned to obtain the necessary care, treatment and rehabilitation services and the application is granted;
- b) at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that –
  - i. the user is likely to inflict serious harm to himself or herself or others; or

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<sup>95</sup> Mental Health Care Act 17 of 2002

- ii. care, treatment and rehabilitation of the user is necessary for the financial interests or reputation of the user; and
- c) at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required.”

Thus it can be seen that the justification needed to override the need to obtain informed consent is harm to himself or others, or that the user will harm himself financially or his reputation. The fact that the legislation details the need for justification and sets it out so succinctly illustrates how important the concept of informed consent is viewed even when dealing with people with mental disorders.

If the patient regains the ability to give informed consent during his treatment, then he must be given the option to either continue his treatment on a voluntary basis or if he does not exhibit symptoms of a mental illness must then “immediately cause the user to be discharged according to the accepted clinical practices”.<sup>96</sup>

## Conclusion

Thus it can be seen that, with regard to mental health care users in South Africa, informed consent is still of the utmost priority as the autonomy of the patient must be respected at all times. As can be seen from the legislation the only justification to not get the patient’s informed consent is that he or she has a mental illness that will cause him to harm his interests; whether physically, financially or his reputation. It is important to ascertain whether the person indeed has a mental illness as, without such a diagnosis, the medical practitioner has no right in trying to paternalistically protect patients.

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<sup>96</sup> Mental Health Care Act 17 of 2002. Section 38: Recovery of capacity of involuntary mental health care users to make informed decisions.

## Chapter 8

### Ethical Rules Pertaining to Informed Consent

#### Introduction

The medical profession takes particular note of the ethics involved in the practicing of the profession. It is no coincidence that the laws regulating the profession will be mostly in line with that of the ethics surrounding the profession. Furthermore, when no law has been put forward for a certain aspect the profession as well as the courts will follow what the ethics of the situation call for. In this chapter we will look at the ethics involved in informed consent and see how well they fit in with the law pertaining to informed consent.

The medical profession has adopted the four pillars<sup>97</sup> of autonomy, non-maleficence, beneficence and distributive justice on which to lay the foundations for all medical ethical questions. The principle which most applies to ethical decisions pertaining to informed consent is autonomy. Autonomy is defined by the Cambridge Advanced Learner's Dictionary as: "the right of a group of people to govern itself, or to organize its own activities."<sup>98</sup> Taken in terms of the principle of informed consent it can be seen that informed consent is the ability of a patient to decide for him or herself what procedures to be subjected to and what not to be subjected to and thus have control over their body and mind.

The body which sets out the ethical guidelines for medical professions in South Africa is called the Health Professions Council of South Africa. It is thus important to ascertain what their requirements for informed consent are. This can be seen by looking at the document entitled the *General Ethical Rules Booklet 2*. In section 27A titled "Main responsibilities of health practitioners it states:

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<sup>97</sup> Beauchamp TL, Childress JF *Principles of biomedical ethics* (2001) New York: Oxford University Press.

<sup>98</sup> (2005) Cambridge: Cambridge University Press 75

“27A. A practitioner shall at all times

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

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

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

Thus it can be seen that the ethical rules match the legal criteria set out by Ackermann J in *Castell v De Greef*<sup>99</sup> as stated above.

The doctor and patient’s ethical considerations may not at times be fully aligned. Sometimes the patient’s refusal to have an operation done or consent to taking certain medication may be in direct conflict with the doctor’s need to do good which is encapsulated in the term beneficence.<sup>100</sup> The doctor may want to help a patient and the family of the patient may even urge the doctor to help the patient that does not want treatment. However, in a society that values the autonomy of the individual it is paramount that the individual has full control in decisions related to his body and thus the doctor would not be able to act. It could be argued that any actions by the doctor that would conflict with what the patient had consented to would be a maleficent act by the doctor. I would argue that any so-called beneficent actions by the doctor in such a situation are not beneficent as they in fact hurt the patient if not physically then psychologically and therefore the actions are in direct contradiction with the principle that the doctor seeks to practice.

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<sup>99</sup> [1994] 4 All SA 63

<sup>100</sup> Beneficence is defined by the *Cambridge Advanced Learner’s Dictionary* (2005) Cambridge: Cambridge University Press 109 as: “helping people and doing good acts”.

It must be remembered that autonomy does not necessarily apply to every individual in society as the individual needs to be competent to make such decisions. In *Medical Ethics, Law and Human Rights*<sup>101</sup>, Moodley states:

“This principle should not be used for persons who are not autonomous as a result of their being immature, incapacitated, ignorant, coerced into a decision or exploited. This includes infants and young children, suicidal individuals, some drug-dependent patients, and patients with a severe psychiatric illness that would render them incompetent.”

It is clear from the legal principles outlined in previous chapters that the legislation in South Africa is fully in-line with this thinking. It is impossible to ask a non-autonomous being to make autonomous decisions. However, it then falls to society to be of the strictest ethical concerns when it comes to such individuals to make sure that we do not abuse them with the decisions that we make.

Thus it is clear that the ethical principle of autonomy is what informed consent is based on. It is important to allow the patient to have autonomy and to make his or her own decisions. Medicine left paternalism in the previous century. It must be remembered by medical practitioners that the harm of breaking the patient’s autonomy in order to do something that the doctor feels should be done could actually do more harm to the patient psychologically than the treatment does good for the patient. As Watermeyer J stated in his judgement in *Stoffberg v Elliott*<sup>102</sup>: “a man, by entering a hospital does not submit himself to surgical treatment as the doctor may consider necessary. ... he cannot be treated in hospital as a mere specimen, or as an inanimate object which can be used for the purposes of vivisection; he remains a human being, and he retains his right to control and disposal of his own body;...”<sup>103</sup>

## Conclusion

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<sup>101</sup> (2005) Pretoria: Van Schaik Publishers 42

<sup>102</sup> 1923 CPD 148

<sup>103</sup> Ibid at 149



Thus it can be seen that the ethical considerations of informed consent are fully applied in the legal framework of our country. It is plain to see that the Constitution of South Africa has placed the value of autonomy at the very highest level of our society and that informed consent directly stems from such a right. However, certain groups of society do not have the autonomous capacity to make such decisions and thus ethics and law are in agreement that such people need to be protected and decisions made for them using the best intentions and strictest guidelines in order to ensure that they are not harmed.

## Chapter 9

### Defenses where Informed Consent is not obtained

#### Introduction

As has been seen in previous chapters the principle of informed consent is well entrenched in our society and legal systems. For a medical professional to lawfully perform a procedure on a patient permission needs to be asked for and obtained. However, there are certain circumstances which may arise where the patient cannot give informed consent or refuses to give informed consent where other considerations may arise. The law recognises that such circumstances may present themselves and provides avenues for medical professionals to treat patients without breaking the law. These avenues are: *negatorium gestio*, necessity, therapeutic privilege, statutory authority and court order. These will be dealt with individually below.

#### ***Negatorium Gestio* (Unauthorised administration)**

The law recognises that there are situations where the patient may be unconscious, in a state of delirium, shock or a coma, or due to some other reason is incapable of providing informed consent. If this occurs and it is impossible to obtain informed consent from the patient for a procedure that is urgently needed to save the patient's life or to preserve his or her health, then the medical professional can use the defence of unauthorised administration to defend him or herself. As with the defence of consent, unauthorised administration renders the intervention lawful, provided the following requirements are met:

- a) There must be a situation of emergency which necessitates the intervention (that is, there must be an immediate threat to the patient which precludes waiting for the patient to be able to consent)<sup>104</sup>;

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<sup>104</sup> It was found in *Stoffberg v Elliot* that a two-year and in *Esterhuizen v Administrator, Transvaal* a one-year life expectancy was held to be sufficient to obtain the patient's consent and insufficient for purposes of an emergency.

- b) The patient must be incapable of consenting to or unaware of the intervention. If the patient is able to consent then such must be obtained. The fact that there is a life-threatening situation alone does not automatically allow for the overriding of the patient's autonomy. Thus this defence can only succeed where it is impossible to procure the patient's consent;
- c) The intervention must not be expressly prohibited or against the patient's will. The defence implies that had the patient been able to do so he or she would have consented to the procedure. Therefore, if the patient's direction or will is known the medical professional may not go against it.
- d) The intervention must be intended to be in the patient's best interests. The medical intervention must be intended to save the patient's life or to protect his or her health.

It should be noted that Carstens in *Foundational Principles of South African Medical Law*<sup>105</sup> refers to several other requirements that were put forward by Strauss and Van Oosten. Briefly these are:

- The duty to complete treatment: the doctor who comes to the patient in terms of the unauthorised-administration defence has a duty to complete such care as may be practiced by a reasonable practitioner performing the intervention
- The right to remuneration: provided that the practitioner acted with the intention to claim compensation for such act, the practitioner may claim expenses such as were incurred from the patient.
- The right to compensation: if the practitioner were to come to some harm then he or she would be entitled to claim compensation from the author of the emergency provided the author was negligent in causing the emergency.

## **Necessity**

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<sup>105</sup> Carstens P, Piermain D (2007) Durban: LexisNexis 908

Necessity is a ground of justification that defends the conduct of the practitioner in when the intervention performed was in protection of the person's or somebody else's legally recognised interest that is endangered by a threat or harm the author of which may be either a human being or a natural force). The defence may not require that the intervention be performed in the best interest of the individual patient, and broader considerations of society's best interests are relevant here. The requirement for the successful defence of necessity are:

- a) There has to be some form of emergency situation;
- b) It does not require that the patient was incapable of consenting or that the intervention must not be against the patient's will or that it must be in the patient's best interests. Thus necessity is used when the patient is capable of consenting or where the intervention is performed against the patient's will;
- c) The medical intervention is to be performed in society's best interests. Thus an emergency intervention can be performed against a patient's stated wishes because in certain instances society's interests have more weight than that of the patient.<sup>106</sup>

The defenses of Unauthorised Administration and Necessity may be confused by some. Carstens in *Foundational Principles of South African Medical Law*<sup>107</sup> refers to an LLM dissertation by Steyn wherein the differences are the two are succinctly pointed out. It states:

- “1) Necessity involves the sacrifice of the interests of an innocent third party, whereas unauthorised administration involves two parties: the caretaker and the beneficiary;
- 2) necessity protects the interests of society, whereas unauthorised administration protects the interests of the individual;

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<sup>106</sup> The Constitution specifically provides for the limitation of a person's rights in section 36. It states: “(1) The rights in the Bill of Rights may only be limited in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors...”.

<sup>107</sup> Carstens P, Piermain D (2007) Durban: LexisNexis 909

3) unauthorised administration protects a pecuniary interest, whereas any legally recognised interest may be protected in necessity”.

### **Therapeutic Privilege**

The defence of therapeutic privilege is thus named to indicate the special “privilege” that the medical practitioner may have of knowing what procedure the patient may need and the fact that the patient may not consent to such procedure if he or she knew certain facts. Thus we return to paternalism on the part of the practitioner that is allowed for because it is seen as best for the patient’s interests. This principle directly goes against patient autonomy and thus interventions which call for this defence must be done in specific circumstances as it will carry a heavy burden of evidence that the practitioner must provide to show that it is not abused as a false justification to not secure informed consent. This defence has been legislated as part of two acts. The first being the National Health Act<sup>108</sup>. Wherein Section 8 titled, Participation in decisions, subsection 3 it states:

“If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user’s best interests.”

The second being the Promotion of Access to Information Act<sup>109</sup> wherein section 30, titled: Access to health or other records, subsection 3 it states: “(a) If, after being given access to the record concerned, the health practitioner consulted in terms of subsection (1) is of the opinion that the disclosure of the record to the relevant person would be likely to cause serious harm to his or her physical or mental health, or well-being, the information officer may only give access to the record if the requester proves to the satisfaction of the information officer that the adequate provision is made for such counselling or arrangements as are reasonable practicable

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<sup>108</sup> No 61 of 2003

<sup>109</sup> No 2 of 2000

before, during or after the disclosure of the record to limit, alleviate or avoid such harm of the relevant person.

(b) ...”

Thus it can be seen that there are relevant provisions specifically provided for in the legislation that allows for the defence of therapeutic privilege. However, it must be remembered that ethically such a provision is questionable and should not be taken lightly.

### **Deviations or extensions**

There are many instances where medical practitioners find that they need to extend or deviate from a procedure that consent was obtained for. This oftentimes happens in surgery where the patient’s condition is further advanced or worse than anticipated; another body member or organ is also affected; or an undiagnosed condition exists. The brevity of this work does not allow for a full discussion of the legal ramifications of such a defence. However, it should be noted that in and of itself a deviation or extension should be judged based on the principles previously stated for unauthorised administration and necessity as most times the extension or deviation if looked at as its own operation can be judged using the criteria set out there.<sup>110</sup>

### **Statutory Authority**

This defence can be used when the intervention performed on the patient is authorised by statute. Carstens in *Foundational Principles of South African Medical Law*<sup>111</sup> follows others in dividing this into three kinds of situations where statutory authority may justify a medical intervention. They are:

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<sup>110</sup> For a more in depth discussion see Carstens P, Permain D *Foundational Principles of South African Medical Law* (2007) Durban: LexisNexis 912-917, where this is fully discussed.

<sup>111</sup> Carstens P, Piermain D (2007) Durban: LexisNexis 917

- Instances where consent is irrelevant: a statutory provision that may justify a medical intervention or disclosure of information irrespective of whether or not the patient consents to it.
- Instances with consent: not applicable to our discussion
- Instances in emergencies: In emergency situations statutory authority may justify the medical intervention, in which case the justifications of necessity and statutory authority may overlap.

## **Court Order**

A court order may justify a medical intervention. Such may arise where there is a conflict of beliefs which legislation does not specifically provide for and thus the parties affected seek a court order to allow for the intervention. Cases which specifically have occurred for such would be *Hay v B*<sup>112</sup> where the religious beliefs of the parents precluded the life-saving blood transfusion of their child. The doctor succeeded in obtaining a court order allowing for the transfusion. Thus it can be seen that wherever a court order is granted for a medical intervention it is obviously lawful and will be a justification.

## **Mistaken Belief**

It should be noted that the medical practitioner may use the defence of ignorance or mistake as a ground that excludes fault, depending upon whether or not its requirements are satisfied. The medical practitioner could use such a defense in a case where for one or other reason he or she was completely unaware that consent had not been given or alternatively believed that consent had in fact already been granted<sup>113</sup>.

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<sup>112</sup> 2003 (3) SA 492 (W)

<sup>113</sup> Van Oosten FFW. *The Doctrine of Informed Consent in Medical Law*. (unpublished LLD thesis, UNISA, 1989)

## Conclusion

It can thus be seen that there are numerous different defenses that can be advanced in defence of a medical practitioner performing a medical intervention without the patient's consent. These defenses allow for the practitioner to perform procedures that may be called for in order to protect the patient's interests, as in unauthorised administration, and/or in society's interests, as in necessity. It must be remembered that performing an intervention without the patient's consent goes against the principle of autonomy of the individual and thus should never be taken lightly. This is clearly a case where something that is legal may not be ethical. However, it is important that such defenses exist to protect those practitioners who wish to uphold the principle of beneficence which may come into conflict with patient autonomy in some occasions.



## Chapter 10

### Conclusion

This dissertation has set out the importance of informed consent as a right of the patient. It has been seen that this right permeates South African Law from the highest law in the land; the Constitution of the Republic of South Africa right through to case law where various cases have been argued based on the failure of the medical personnel to obtain informed consent. Informed consent is part of the shift in medicine from a paternalistic environment to one in which patients have control over their own bodies and the right to make decisions about what happens to it.

The doctrine of informed consent plays a major role in modern medicine as it must be implicitly or overtly obtained before any procedure is done to a patient. It is thus reasonable for specific instances of informed consent to be applied to different groups of people in society. The chapters dealing with the different groups, such as children and the mentally incompetent show that just because a patient may not have capacity does not mean that the doctor has the power to automatically decide for the patient.

However, perhaps because of the breadth of informed consent and the relative newness of this concept, the legal fraternity seems to be at odds as to whether failure to obtain informed consent is wrongful or negligent behaviour on the part of the medical personnel. The difference is important as there are different tests applied from the one to the other. In this dissertation the argument has been put forward that the correct approach would be for this conduct to be found as wrongful and it is the hope of the author that the legal fraternity would one and for all accept this as the correct approach.

Unfortunately, even with all the legislation pertaining to informed consent, the state and care of medical personnel in obtaining such in the actual medical facilities is of a woeful status. This is especially true of public healthcare where patients may not even understand the doctors involved due to

language barriers, poor education and do not have any legal recourse due to their impoverished status.

It is the author's hope that this dissertation is not only used by the legal profession but also by the medical profession. It is ultimately the medical profession that will face legal action if there is a lack of informed consent. Even in a case where the doctor has a difficult patient and struggles to obtain informed consent there are some rules that will help save the doctor unnecessary legal complications. These are the four golden rules put forward by Strauss<sup>114</sup>:

- "Obtain consent from the person legally competent to give consent.
- Obtain an informed consent.
- Obtain a clear and unequivocal consent.
- Obtain a comprehensive consent."<sup>115</sup>

Even though these rules were put forward in 1991 they still hold as true today as they did then.

It is the author's hope that such a work as this may be used by the legal fraternity and patients in order to bring the doctrine of informed consent in South Africa to the public's attention and thus for patients to demand that their rights are upheld by medical personnel. Ultimately it is the patients' right to have control over their bodies and therefore they must take the necessary action to make sure such rights are upheld.

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<sup>114</sup> Strauss, S. A. *Doctor, Patient and the Law: A Selection of Practical Issues*. (1980)

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<sup>115</sup> Ibid at 4

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## Appendix A

### Informed consent checklist<sup>116</sup>

- User's health status
- Range of diagnostic procedures available to the user
- Range of treatment options available to the user
  - Benefits associated with each option
  - Risks associated with each option
  - Costs associated with each option
  - Consequences associated with each option
- Right to refuse health care services
- Implications, risks and obligations of such refusal
- The information must be given in a language that the user understands and takes into account the user's level of literacy.

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<sup>116</sup> This checklist is in accordance with the requirements of full knowledge that the patient should have as detailed in section 6 of the National Health Act, 61 of 2003