**TITLE: Chronicles of communication and power: Informed consent to sterilisation in the Namibian Supreme Court’s *LM* judgment of 2015**

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**ABSTRACT**

The 2015 judgment of the Namibia Supreme Court in *Government of the Republic of Namibia v LM and Others* set an important precedent on informed consent in a case involving the coercive sterilisation of HIV-positive women. This article analyses the reasoning and factual narratives of the judgment in applying Neil Manson and Onora O’Neill’s approach to informed consent as a communicative process. This is done in an effort to understand the practical import of the judgment in the particular context of resource constrained public healthcare facilities through which many women in southern Africa access reproductive healthcare. While the judgment affirms certain established tenets in informed consent to surgical procedures, aspects of the reasoning in context demand more particularised applications of what it means for a patient to have capacity and to be informed, and to appropriately accommodate the disruptive role of power dynamics in the communicative process.

**KEYWORDS**

Informed consent; sterilisation; HIV/AIDS; human rights; Namibia; southern Africa

**COMPLIANCE WITH ETHICAL STANDARDS**

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One of the authors of this study was involved in the litigation at the Namibian Supreme Court in support of the three respondents.

**INTRODUCTION**

In November 2014, the Supreme Court of Namibia delivered its judgment in *Government of the Republic of Namibia v LM and Others* [1] (henceforth, *LM*), which dealt with the sterilisation of three women living with HIV without their informed consent. The *LM* case exemplifies a broader and seemingly ongoing pattern in the southern Africa region where women living with HIV have reported being sterilised without their informed consent, including in Botswana, the Democratic Republic of the Congo, Lesotho, Malawi, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe.[[5]](#footnote-5)

In the *LM* decision, the Supreme Court of Namibia’s reasoning is based largely on legal principles that are applicable in many jurisdictions in southern Africa where coerced sterilisation is reported: medical intervention without consent is unlawful and potentially invites liability against both the healthcare provider and healthcare institution. The African Commission on Human and Peoples’ Rights has also condemned the practice of ‘involuntary sterilisation’ as a violation of the human rights to equality, non-discrimination, dignity, liberty, and security of the person, and freedom from torture, cruel, inhuman, and degrading treatment, as well as the right to health as enshrined in regional and international human rights law [8]. The judgment should therefore be of concern to medical practitioners, hospital administrators, policy-makers, and patients throughout the region as it articulates legal obligations and ethical concerns beyond Namibia’s borders.

This article applies Neil Manson and Onora O’Neill’s approach to informed consent as a communicative process [9] to a legal analysis of the judgment’s findings. The aim is to untangle the legal, ethical and practical import of what the judgment reflects about informed consent for surgical procedures in the particular context of sexual and reproductive healthcare for women in resource-constrained environments.[[6]](#footnote-6) The intent is to ensure that the decision can speak to the lived realities of patients and healthcare practitioners in the context in which healthcare is provided, as reflected in the facts of the case. While we acknowledge the scope for criticism of the Court’s reasoning, our intent here is to develop a practicable understanding of how the legal and ethical norms it reflects can be applied in context.

The analysis commences with a description of the facts of the case and the Court’s decision. We examine certain aspects of the Court’s judgment that reflect what are often understood to be gold-standards of informed consent, as well as those aspects of the judgment that reflect more contested and practically constrained applications of informed consent. We highlight, in particular, the judgment’s reflection of the role of power disparities in the informed consent process.

# CASE BACKGROUND

The *LM* case concerns three women who were sterilised by bilateral tubal ligation between 2005 and 2007 in state hospitals in Namibia. Tubal ligation is a procedure in which a patient’s fallopian tubes are cut or blocked to prevent pregnancy. All three women claimed individually that they had not consented to the procedures, which were performed at the same time as emergency caesarean sections. The circumstances surrounding the first respondent’s sterilisation are elaborated below to give context.

The first respondent tested positive for HIV when accessing antenatal care. She was 26 years old at the time. While the use of antiretroviral treatment to ensure the health of her unborn child was discussed with her, she testified that sterilisation was not discussed during antenatal care visits. She was admitted to the clinic after commencing labour and experiencing severe pain. A doctor examined her and diagnosed her with Cephalopelvic Disproportion, a condition in which the unborn child is too large to progress through the pregnant mother’s pelvis. A nursing student who spoke Oshiwambo, the first respondent’s mother tongue, translated for the attending doctor. The nurse explained that the first respondent would need a caesarean section, to which she did not object.

The first respondent testified that a nurse later approached her and informed her that she would have to have her uterus removed, as did all HIV-positive women. This occurred eight hours after commencing labour. This discussion was not noted in the hospital’s records. The nurse then presented documents for the first respondent to sign, which the first respondent did not understand and which, she testified, were not explained to her. The consent form used only abbreviations to refer to the caesarean section and sterilisation procedures: ‘C/s due to CPD + BTL (on HAART)’. The patient signed the consent form in severe labour pain, while waiting for her caesarean section. She was taken to theatre immediately thereafter. Her child was delivered by caesarean section, following which a bilateral tubal ligation was performed.[[7]](#footnote-7)

The first respondent only discovered that she had been sterilised upon returning to the clinic to obtain contraceptives sometime after the caesarean section. The Court noted that she only came to understand fully what sterilisation meant on visiting a doctor in preparation for the court case. A medical doctor testified in the High Court that her prognosis for reversing the sterilisation was very poor, as it had not been performed with reversal in mind.

The first respondent testified that she never consented to being sterilised as she intends to have more children. Her medical records indicated no prior request that she be sterilised. The attending doctor testified that although the first respondent was in labour at the time when she consented to the procedure, she ‘must have’ requested it and that the option of sterilisation and its consequences were in all likelihood explained to her during her group counselling antenatal classes.

The three women instituted an action against the Namibian Government in the High Court, seeking financial damages for having been unlawfully sterilised. The women argued that the non-consensual procedures violated their common law personality rights, as well as their constitutional rights to dignity, liberty, and the right to found a family. The women also argued that the acts were discriminatory because they were performed on the basis that they were HIV-positive.

The High Court ruled in the women’s favour, holding that the State had failed to prove that the three patients had given their informed consent to the sterilisation procedures, rendering the procedures unlawful [10].[[8]](#footnote-8) The High Court found, however, that there was insufficient evidence to prove that the procedures were conducted on the discriminatory basis of the women’s HIV-status.

The Namibian Government appealed the decision to the Supreme Court. The Court, per Chief Justice Shivute, dismissed the appeal and upheld the High Court’s order that the women be granted damages. For all three women, the Supreme Court held that because the consent for the sterilisation procedures was sought during the height of labour, any agreement given was invalid because the women lacked the capacity to consent in that condition.

# A BASIC LEGAL FRAMEWORK ON THE OBLIGATIONS OF INFORMED CONSENT

The *LM* judgment affirmed that, legally, informed consent in Namibia requires the presence of the three independent legs of knowledge, appreciation, and consent to be present within the context of certain preconditions relating to the capacity and will of the patient [1, para. 98].The Court held that the decision to be sterilised

must be made with informed consent, as opposed to merely written consent. Informed consent implies an understanding and appreciation of one’s rights and the risks, consequences and available alternatives to the patient. An individual must also be able to make a decision regarding sterilization freely and voluntarily. [1, para. 3]

We employ the term ‘informed consent’ in this article to signify a process that accommodates all of these criteria. This is opposed to the unqualified term ‘consent’ which is used here to signify the stage in the informed consent process in which the patient approves or accepts, whether in written form or otherwise, to undergo the procedure in question.

While there is variance in the legal sources and boundaries on the obligation to obtain informed consent to surgical procedures across jurisdictions in the southern Africa region, some common standards apply. In most common law jurisdictions in southern Africa, physically interfering with another person’s body is delictually wrongful unless there is a valid ground of justification. Informed consent in the context of medical care is one such justification.[[9]](#footnote-9) If a healthcare provider wrongfully treats a patient in the absence of informed consent, she may be liable to the patient personally in delict if she does so with the requisite fault and causes harm to the patient.[[10]](#footnote-10) While there is some variance across jurisdictions, if the healthcare provider acts with the necessary standard of knowledge of the wrongfulness of her conduct, the healthcare provider may in addition be criminally liable for assault.[[11]](#footnote-11) Contractual liability may also arise in the absence of informed consent to a surgical intervention between patient and healthcare provider as between patient and healthcare institution.[[12]](#footnote-12) Healthcare institutions can be held vicariously liable for the negligent conduct of their staff.[[13]](#footnote-13) The legal obligation to ensure informed consent to surgical procedures may also arise from legislation such as in the South African Sterilisation Act 44 of 1998, which prohibits sterilisation without the informed consent of persons capable of consenting [16].[[14]](#footnote-14)

# INFORMED CONSENT: A COMMUNICATIVE PROCESS

While informed consent is a complex and somewhat idealised process [21], understanding the legal requirements for informed consent as ‘communicative process’ (as developed by Manson and O’Neill [9]) may be a valuable point of departure for healthcare providers and patients. We apply this conceptual framework to our understanding of the judgment to reflect critically on some of the challenges of ensuring the integrity of the informed consent process in resource-constrained environments.

The *LM* judgment, it can be argued, accommodates an understanding that informed consent is a communicative process, that is, a communicative transaction or a series of communicative acts [9]. This is affirmed in the Court’s rejection of the idea that a consent form is sufficient legal evidence of informed consent. Instead the Court views informed consent as a process comprised of various stages, beginning with a healthcare provider transmitting information about the consequences, risks, and alternatives of undergoing or declining a procedure, the patient understanding that information, and the patient clearly communicating approval for the procedure, unencumbered by any lack of capacity or voluntariness that would render the process invalid.

As a *process*, informed consent can be understood to comprise a series of exchanges. As *communication*, informed consent in surgical procedures involves at least two actors, both of whom are required to participate and to be able to participate for the exchange to be effective. In resource-constrained public hospitals in the southern Africa region, a variety of actors may interact with a patient during the course of care, exchanging various components of the communicative transactions over interrupted periods of time. As the facts in the *LM* case illustrate, lay counsellors conducted group counselling, explaining to patients submitting to antenatal care a variety of contraceptive options with varying levels of detail and patient responsiveness. Nurses solicited the patients’ signatures on consent forms at a later date, following hospital admission for labour. When the surgeons met the patients, they performed the sterilisation procedures on the presumption of the integrity of the preceding communications. Manson and O’Neill’s view of informed consent as ‘complex social and communicative transactions’ [9, p. 31] finds expression and particular meaning in these narratives.

**Achieving ‘uptake’**

In order for a particular communicative exchange to be successful, ‘uptake’ must be achieved. Uptake occurs when the hearer recognises the speaker’s intention [22]. It is clear that various factors can inhibit uptake. Manson and O’Neill note that communicative transaction can be inhibited if the participating parties lack a common language, have different understandings of the same terms, or lack shared background knowledge [9, pp. 56-57]. Analogously, the Court in the *LM* case quoted with authority the *dicta* in a 1904 South African case, *Waring and Gillow Ltd v Sherborne*, in which it was held that ‘knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to [informed] consent.”[[15]](#footnote-15)

In this context, the facts in the *LM* case illustrate factors that can disrupt a patient or a healthcare provider’s uptake of information. For example, patients and healthcare providers did not share a common language, education, or socio-cultural background. In addition, highly technical terms, which were not known to the patients, were represented as acronyms on the consent forms. It cannot be assumed that these terms or acronyms convey any meaning sufficient to achieve uptake by lay patients or illiterate patients.

The *LM* judgment also makes it clear that a range of other factors might damage the quality of the communicative transaction and inhibit successful uptake from occurring. For instance, busy medical staff might not adequately explain the medical procedure, compromising disclosure of details and understanding.[[16]](#footnote-16) The pain of labour might interfere with the patient’s ability to recognise fully the speaker’s intention, thus inhibiting uptake, with the result that consent is not achieved.

In order to ensure that uptake is achieved, healthcare providers may consider adopting ‘repeat back’ procedures that are often employed in informed consent processes for clinical trials. This typically involves requesting a patient to repeat back in their own words their understanding of the procedures explained to them. This has potential to ensure that the patient has not only heard the information provided in relation to the medical intervention but appreciates and understands it fully, giving the healthcare provider further opportunity to correct any misconceptions.

**Communication between healthcare providers**

The facts of the *LM* case highlight an additional dimension to achieving uptake in the informed consent process that may have particular relevance in resource-constrained public hospitals or clinics, where communication breakdown also occurs between healthcare providers exchanging the terms of their individual communications with the patient.

One of the doctors involved in the sterilisation of the third respondent in the *LM* case testified that ‘ordinarily she would not discuss the sterilisation procedure with a patient in detail but would refer the patient to medical officers and to antenatal care classes’ [1, para. 80]. The doctor testified that in order to give informed consent, individual counselling is not necessary [1, para. 85]. The nurse who had prepared the second respondent for the procedures ‘assumed’ the patient ‘wanted to be sterilised’ because of the inscription ‘BTL’ (presumably for ‘bilateral tubal ligation’) on her ‘health passport’. The judgment does not interfere with the idea that multiple parties can be involved in communicating with a patient during the informed consent process, nor does it overtly comment on the adequacy or otherwise of group settings when conveying information for informed consent purposes. However, the case brings into focus the complexity of informed consent as a communicative process when so many actors are involved in the exchange. Strategies to ensure effective communication are considered below.

# AN ABSTRACT IDEAL IN PRACTICAL CONTEXT

The testimonies in the case speak to some additional difficulties that healthcare providers may face in resource-constrained environments. The doctor who performed the third respondent’s caesarean section and sterilisation testified that the hospital where he worked had a shortage of staff, and that staff worked under immense pressure and were constrained by time and the availability of theatres [1, para. 58, 60]. The nurse who took the first respondent’s consent in effect testified to having perused the patient’s records, called the doctor, waited for him to arrive, briefed the doctor, completed the consent form (while translating), and prepared the patient for theatre all within 15 minutes [1, para. 45]. She testified that ‘saving the respondent’s baby’s life in an emergency situation’ was ‘more important than fully completing the medical record’.

Is it possible for healthcare providers to achieve the idealised abstract notions of informed consent under these conditions? We relate some of the judgment’s findings on practical constraints and interventions in what follows.

## Consent forms are not informed consent

In certain respects, the *LM* judgment confirms some rather uncontroversial tenets of informed consent in law and medical ethics. The first is reflected in how the Court refused to take the mere existence of the patient’s signature on a consent form as conclusive proof of the integrity of the informed consent process. At best, the written consent form is a mere recording of the ‘consent’ stage of the informed consent process. In the *LM* case, it did not reflect whether or not the patient understood what sterilisation involved and meant for her, nor whether she factually, voluntarily, and with the requisite capacity agreed to the procedure. The judgment, in this manner, affirms the importance of the substantive integrity of the process. When healthcare institutions operate under staff constraints, as the hospitals did in the *LM* case, a tokenistic approach can easily reduce the goal of the process to merely obtaining the patient’s signature.[[17]](#footnote-17) Healthcare providers and trainees should be educated on the legal and ethical importance of the informed consent process as a whole.

## Each (non-emergency) procedure requires informed consent

Given the Court’s dismissal of the evidential weight of a single consent form as proof of informed consent to sterilisations, it is clear that the patient’s signature does not absolve a hospital or healthcare provider of liability. As a corollary, the judgment affirms that each and every non-emergency procedure performed on a patient requires informed consent, irrespective of whether the agreement stage of those processes are recorded on one or separate consent forms. There can be no universal consent on admission.

The judgment very clearly distinguishes voluntary and emergency procedures and clarifies that sterilisation is almost never an emergency procedure.[[18]](#footnote-18) The Court held that, ‘unlike some life-saving procedures that require intervention on a moment’s notice, sterilisation allows time for informed and considered decisions’ [1, para. 106].

Considering the legal consequences of these findings, healthcare institutions might consider, as a practical measure, requiring separate consent forms for each separate procedure to be performed on a patient. At the clinic where the first respondent in the *LM* case was sterilised, one standard consent form was used for all procedures. Separate forms for specific operations were introduced only at a later stage.

In addition, it may be valuable to put in place precautionary measures to ensure the integrity of the informed consent process for any elective procedures that, in rare cases, need to be performed at the same time as emergency procedure. This may require advance counselling. As stated by the Supreme Court, a ‘patient should not be counselled for the first time about sterilisation while experiencing active labour’ [1, para. 85]. In its recommendations to the Namibian government following the Court case, the Committee on the Elimination of Discrimination against Women urged the government to adopt legislative and policy measures that clearly define the requirement of free, *prior*, and informed consent with regard to sterilisations.

Aspects of the judgment’s reasoning may indicate, however, that it is advisable to avoid elective sterilisation from ever being performed following admission for an emergency procedure. This is because even if the patient is informed, she may not be in a position to consent to the procedure under the strain of conditions likely to be experienced when submitting for emergency care. In addition, even if she is fully informed and consented to the elective procedure prior to admission for emergency care, her ability to withdraw wilfully her prior decision may be compromised.

In the case of the third respondent, the doctor attending to her sterilisation agreed that if the procedure is discussed with the patient for the first time during active labour, ‘her consent should not be accepted’ [1, para. 87]. The Court found it significant in the case of the first respondent that although she had been informed of sterilisation as part of general antenatal care education, ‘there was no evidence that she was informed about undergoing sterilisation as a method of birth control. She was only informed about sterilisation after being in labour for about eight hours’ [1, para. 90].

In the case of the second respondent, even though the Court held that the evidence showed that the patient had ‘opted for sterilisation some time in the future, she still had the opportunity to change her mind and her [agreement] should not have been obtained at the height of labour when it was difficult to make a rational and informed choice’ [1, para. 93]. The inference from this latter finding is that should healthcare institutions wish to avoid infringing on a patient’s rights, and thereby avoid liability, it is generally inadvisable to perform voluntary sterilisations at the same time as emergency procedures because the integrity of the informed consent process cannot be guaranteed.

It is recalled here that the Court’s decision grounded the legal invalidity of the sterilisations on the fact that the patients lacked the *capacity* to consent while in labour. While not explicit in its reasoning, the Court’s repeated observation in the above quotes that the pain of labour invalidates the requirement that the patient’s consent be *informed* is indicative of a comprehensive approach to the notion of a patient’s capacity. A patient must have not only the capacity to consent but also the capacity to be informed. The effect of labour pain therefore need not be understood as universally excluding the prospect of valid informed consent. A patient experiencing labour pain may, for example, still be able to give informed consent for epidural analgesia.[[19]](#footnote-19) This can be understood to differ from the patient’s capacity to be informed as to the *consequences* and permanence of sterilisation, and fully appreciating those consequences, during the height of labour.

## Communicating consequences, risks, and alternatives

The Court in the *LM* case quite distinctly emphasises the importance of communicating the consequences of and available alternatives to the procedure and not just the risks of the intervention: ‘Informed consent implies an understanding and appreciation of one’s rights and the risks, consequences and available alternatives to the patient’ [1, para. 3]. Referring to the South African judgment of *Castell v De Greef* [12], the Court held that the patient’s consent must be comprehensive, extending to the *entire* transaction, inclusive of the consequences [1, para. 98].

This is of some significance. The term ‘informed consent’ is credited to an American lawyer Paul G. Gebhard, who first deployed it in the case of *Salgo v Leland Stanford Jnr University* [27]. From that first use of the expression in the decision of Judge Bray in that case, the ‘informing’ component of informed consent is almost exclusively expressed as requiring the communication of risks:

A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent. [28]

Discussions in comparative case law on the duty of the healthcare provider to inform a patient often centre primarily on the communication of risk. The inclusion of a requirement to inform the patient of alternative treatments is understood to have moved the comparative jurisprudence on informed consent towards a more patient-centric approach.[[20]](#footnote-20) However, discussions of *consequences* are not as clearly emphasized. It may well be that the specification of the obligation to inform a patient of the *consequences* of a procedure is either considered so trite as not to require specification or assumed to be part of the duty to inform a patient of risks and alternatives in a particular intervention.

However, the specification that the informed consent process must be comprehensive and extend to the entire transaction, inclusive of its consequences,[[21]](#footnote-21) has been an important development of the law and is valuable in its articulation in the southern African context. The assessment of the evidence in the *LM* case referred extensively to whether the patients had understood the consequences of the procedure. By emphasising a comprehensive approach to the healthcare practitioner’s requirement to communicate risks *and* consequences to the patient, and in embracing the reasoning in the *Castell v Greef* decision, the judgment advances a patient-centric approach. It thereby emphasises the patient’s autonomy and self-determination as opposed to what are arguably more paternalistic, physician-centred approaches that favour the healthcare practitioner’s right to determine what amounts to ‘reasonable disclosure’.[[22]](#footnote-22)

The Court considered in evidence the Namibian Ethical Guidelines for Health Professionals, which states, ‘everyone has the right to be given full information about the nature of his or her illnesses, diagnostic procedures, the proposed treatment and the costs involved’ [1, para. 96].[[23]](#footnote-23) To the extent that this articulation of the legal and ethical requirements of the informed consent process fails to make clear the requirement that consequences of a procedure, as well as risks, must be communicated effectively to the patient, the Guidelines may require revision or further specification.

In contexts where healthcare access is limited, healthcare practitioners may not often consult with patients seeking elective or non-critical care. It is easy to understand that the informed consent process can become routinely thinned out when the majority of patients that a healthcare provider deals with submit for care in a state of emergency or when the desired consequence from a treatment regime is easily presumed to be a common cause. It is perhaps safe to assume that a patient in the height of labour desires to give birth to her child, or that a patient seeking treatment for respiratory failure desires improved vitality and respiratory function. Making clear the consequences, and not just the risks, of an intervention perhaps are not ordinarily the focus of a healthcare practitioner’s communication with the patient, with whom a shared consensus on desired outcomes may be safely assumed.

Sexual and reproductive services like family planning and contraceptive care, however, are distinct in that the desired consequences of a particular medical intervention can seldom be assumed to be shared between patient and healthcare provider. While healthcare providers may have superior knowledge regarding the risks, benefits, and consequences a particular treatment regime offers, they should not assume superior knowledge regarding which consequences are desirable to a patient or in the patient’s best interests. It is therefore quite possible that patients understand the risks of the procedure (for example, that they may experience adverse reactions to anaesthesia, wound infection, or prolonged abdominal pain following tubal ligation) but do not fully appreciate certain consequences (for example, that beyond the contraceptive result of tubal ligation, they will experience permanent infertility). It is possible that the patient’s priorities in respect of the desirability of consequences will differ drastically from those of the healthcare provider.

## Material risk

In legal terms, in some jurisdictions, a healthcare provider’s decision on whether information is relevant and appropriate to convey to a patient is measured with reference to standards of ‘material risks’ for the medical practice, at that time, as determined by a responsible body of medical opinion.[[24]](#footnote-24) Medical evidence and health professionals’ determination of its materiality is thus determinative. However, in embracing the trend of reasoning in *Castell v De Greef*,[[25]](#footnote-25) the Court in the *LM* judgment arguably positions itself more in line with reasoning that considers not only medical professionals’ perspectives on what information is material to convey to a patient but also notions of materiality as determined in reference to the patient’s particular context. The Court thereby embraces a more patient-centric approach. For example, the Supreme Court of Canada in *Riebl v Hughes* held that:

To allow medical evidence to determine what risks [and consequences] are material, and hence, should be disclosed and, correlatively, what risks [and consequences] are not material is to hand over to the medical profession the entire question of the scope of the duty. What is under consideration here is the patient’s right to know what risks [and consequences] are involved in undergoing or foregoing certain surgery or other treatment. The materiality of non-disclosure of certain risks to an informed decision is a matter for the trier of fact, at matter on which there would, in all likelihood be, not only medical evidence but also other evidence, including evidence from the patient and from members of his family. [35]

In many discussions on informed consent, the purpose of the process is understood to be to provide or disclose information to a party as a basis for their *autonomous* decision-making. Ensuring that a patient understands the consequences of and alternatives to electing and forgoing a particular procedure, and not only the associated risks thereto, allows the patient to better consider their personal circumstances and best interests in making a decision. Healthcare providers will, in all likelihood, be ignorant of the materiality and relevance of a patient’s personal interests.

Many women and men living with HIV express a strong personal desire for biological parenthood, despite that healthcare providers may feel that the desire is medically or morally undesirable. A patient’s wish for biological parenthood may be influenced by social values that encourage childbearing [36]. Cultural values around women’s fertility assign significant social status to women who bear children, and childlessness often carries negative social and even economic consequences for women, including divorce, abandonment, and violence [37].

Manson and O’Neill argue that justifications for the ethical requirements of informed consent based purely on autonomy can be problematic. They argue that ‘informed consent transactions serve a variety of purposes over and above the provision of material for decision-making’ [9, p. 32]. These purposes may include protecting healthcare providers from the threat of legal action or establishing a relationship of trust and confidence between patients and healthcare providers premised on a perception of transparency. The communicative transactions comprising the informed consent process are ethically important for a variety of reasons beyond merely its utility as a device for enabling ‘autonomous choice’ [9, p. 34].

## A record of the communication

Indirectly, the judgment in its findings and the narratives of the patients, illustrates further some challenges in the informed consent process that may be more pronounced in the realities of resource-constrained environments.

All the doctors in the *LM* case testified to not recalling their interactions with individual patients. They relied instead on the brief notes they had taken and mostly made assumptions about what occurred based on what they would *ordinarily* do in practice. In relation to the second respondent in the *LM* case, the Court considered the evidence of a nurse who had assumed what the patient’s wishes were based on the acronym ‘BTL’ recorded in her ‘health passport’ and on the basis of speculation on the sort of counselling that would *ordinarily* have been conducted. The Court held that ‘unfortunately … the explanations … are not recorded anywhere in the clinical notes’ [1, para. 92]. The Court could not accept as fact that the informed consent process had been undertaken based on presumptions of ‘the usual process’. The Court also affirmed that the onus falls on the hospital to demonstrate on a balance of probabilities that informed consent was given by a patient.[[26]](#footnote-26)

Wouter Leclercq et al. explain that there is great variance in the recording of the consent stage in surgical informed consent: in the USA, a patient signature is required; in the United Kingdom, a note in the patient’s chart is sufficient; and in the Netherlands, one is not strictly required to obtain written consent [29]. The *LM* case establishes a presumption that a consent form is not in itself evidence of the informed consent process. It highlights the consequential nature of inadequate communication between healthcare providers. It suggests that healthcare providers and institutions must understand paperwork, including consent forms, notes in ‘health passports’, and clinical notes in a patient’s file as tools for communication as opposed to an instrument for effectively disclaiming liability. Ensuring that healthcare providers have the tools and time to effectively record communications and not just signatures is a huge challenge in resource-constrained environments for which creative solutions may need to be adapted.

# THE INTEGRITY AND INDIVIDUALISATION OF THE INFORMED CONSENT PROCESS: UNDERSTANDING POWER DYNAMICS

## The individual context

Standard operating procedures, codes, and requirements alone do not guarantee that abuses of informed consent will not occur in healthcare settings. Understanding the influence of complex socio-cultural factors, the dynamics of the communication process, and the importance of power disparities on the informed consent process remain additionally important.

A patient may be fully informed but nevertheless coerced into signing a consent form for fear of receiving compromised healthcare if consent is withheld. Patient perception, healthcare provider perception, and power dynamics are all important in assessing whether the communicative process is effective and may influence the validity of the patient’s consent. Studies have found that an overriding concern for patients is to receive care and attention for the problems that brought them to seek healthcare in the first place and that many patients perceive that hospital staff expect them to participate or cooperate [38]. Women in the height of labour may have difficulty declining additional elective surgeries for fear of treatment being withheld for their immediate and urgent obstetric treatment needs.

The second respondent in the *LM* case, for example, testified that the doctor was a person in authority and that she was under the impression that there was a policy in place that required all HIV positive women who were pregnant to be sterilised [1, para. 16]. She testified that she did not want to be sterilised but was not informed that she could refuse the procedure. She understood that the procedure for which she was consenting to when signing the form was to save her baby’s life.

Arguably, the Court’s reasoning in the *LM* case establishes that the integrity of the informed consent process cannot be measured in the abstract: it is a process that occurs within a variable and individualised context. The Court held that ‘whether or not the respondents gave their informed consent to the sterilization procedures is largely a factual question. For that reason, it requires a consideration of the circumstances in which the respondents allegedly gave their consent.’ [1, para. 4].

Power dynamics in the communicative process were additionally considered in the Court’s description of gendered understandings of patients’ competence to determine their own best interests in medical care, highlighting how the disenfranchised status of a patient can easily feed into a paternalistic approach to their medical treatment. The judgment states:

The doctors who testified on behalf of the appellant seemed to agree that the third respondent, especially, should be sterilised. Some of the comments made about her were quite cutting, if not bordering on medical paternalism. She was, for example, described by one of her doctors as being ‘unreliable concerning her life care’ and that it felt that she is ‘best helped if she never falls pregnant again’. [1, para. 105]

The judgment’s narratives of the events are important in highlighting how healthcare practitioners may easily perceive markers of vulnerability (such as poverty, HIV status, socio-economic disempowerment, or illiteracy) as signals of the patients’ lack of *capacity* to determine their own best interests. This will surely heighten the dangerous likelihood of a healthcare provider substituting his or her own will for that of the patient’s under the presumption of the patient’s best interests. Power dynamics can certainly be a disruptive factor in the communicative process of informed consent.

It is possible to understand some of these power dynamics under the requirement of being ‘informed’. For example, Manson and O’Neill argue that understanding informed consent as a communicative transaction means that informing someone is seen as something that is, *inter alia*, context dependent, norm dependent, inferentially fertile, and rich in conveying propositional content [9, pp. 26ff.]. This means that healthcare providers need to be aware that the information they seek to convey is not necessarily understood by the patient in the same way that they understand it. Education and training in informed consent should empower healthcare providers to recognise the effect of power disparities in their communication with their patients without allowing the recognition of those power imbalances to interfere with their assessment of the patients’ capacity to understand their own best interests.

**Revealing stigma and discrimination**

The High Court in the *LM* case found that the three women had failed to provide adequate evidence that the sterilisations were performed because of their HIV status: the Court was not convinced that the sterilisations were done on a discriminatory basis. Although this judgment was not appealed, the Supreme Court nevertheless opined in passing that the High Court was correct on this finding. The oral testimonies of the healthcare providers clearly showed that they thought the women *should* be sterilised. While the courts may not have been persuaded on legal terms on the evidence before them that the conduct was discriminatory, it is noteworthy that forced and coerced sterilisation is rooted in eugenics. Historically, this practice has always targeted the most marginalised persons in society, including persons with mental or physical disabilities, racial minorities, poor women, and people living with specific illnesses, such as epilepsy [39]. It is in this sense that the integrity of the informed consent process in sexual and reproductive healthcare is a signifier of discrimination and stigma, revealing the state of institutionalised and socialised ideas on the subjectivity of patients seeking care.

Because access to justice for patients in resource-constrained environments is inhibited, healthcare providers and institutions may be unlikely to receive timeous alerts through legal complaints to a culture of discrimination and stigma against a particular group. In the absence of patients meaningfully asserting their rights, healthcare providers are not incentivised to guard against prejudice, minimising the urgency of self-regulation to ensure incidents do not reoccur. The *LM* judgment and the ongoing revelations of similar practices of coerced sterilisation of HIV-positive women across the southern Africa region are therefore important moments to re-examine ongoing stigma and discrimination in healthcare.

# CONCLUSION

The factual narratives in the *LM* judgment illustrate how, beyond questions of legal liability and culpability, the communication process of informed consent can go wrong on either side. The abstract legal notions of the informed consent process can appear challenging in the particular experiences of public healthcare institutions in resource-constrained environments. By adopting an approach to understanding informed consent as a complex communicative process, we have sought to illustrate how a number of practical interventions at the institutional and policy levels and in the approach of individual healthcare providers towards patients can assist in ensuring the integrity of the informed consent process, both legally and ethically.

Arguably, the institutional and habitual practice of seeing informed consent as part of a legal agenda to avoid liability is dangerous to its own ends. For example, as the judgment illustrates, a focus on the consent form as proof of the informed consent process does not guarantee healthcare institutions or healthcare providers freedom from legal liability. Instead, patient-centric communication and the adoption of practices and procedures that accommodate the multiplicity of partners, languages, and lingos involved in a single instance of informed consent is potentially better equipped to protect patient, institution, and healthcare provider.

The *LM* judgment recognises individual context within the abstract standards of informed consent but establishes the legal role of interpersonal, social, and economic power disparities rather narrowly in the particular factual contexts of the three respondents. Once more, a communication-based understanding of the informed consent process assists in understanding how power disparities can disrupt effective communication without necessarily needing to undermine an understanding of the patient’s intellectual capacity to understand her own best interests.

The *LM* judgment reveals the multiple ways in which HIV-positive women seeking sexual and reproductive healthcare are extraordinarily vulnerable to coercive circumstances in exercising self-determination over their bodies. The ongoing practice of coerced sterilisations documented across the southern Africa region are illustrative of pervasive stigma and discrimination against socially and economically marginalised HIV-positive women.

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5. See, for example, reporting on Botswana, the Democratic Republic of the Congo, Lesotho, and Malawi in [2], on South Africa in [3, 4, 5], on Swaziland in [6], and on Tanzania, Zambia, and Zimbabwe in [7]. [↑](#footnote-ref-5)
6. We refer here to constraints in physical, financial, and human resources as elaborated in the judgment’s narratives to follow. [↑](#footnote-ref-6)
7. It is noted that her uterus was not removed, which the nurse had said was required, as the first respondent testified. [↑](#footnote-ref-7)
8. Neither the High Court nor the Court of Appeal explicitly commented on the validity of the informed consent processes for the caesarean sections as their validity was not before the courts. The courts did however hold all three cases to have involved *emergency* caesarean sections. [↑](#footnote-ref-8)
9. For a statement of legal principles, see [11, para. 78], and see the South African precedent in *Castell v De Greef* [12], *Stoffberg v Elliot* [13], and *Esterhuizen v Administrator, Transvaal* [14]. [↑](#footnote-ref-9)
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12. See *Lillicrap, Wassenaar and Partners v Pilkington Brother (SA) (Pty) Ltd* [17, secs. 499A-500A, 501A-502G] and *Van Wyk v Lewis* [18]. See also *Administrator, Natal v Edouard* [19, secs. 595D-597H]. [↑](#footnote-ref-12)
13. See *Stadsraad van Pretoria v Pretoria Pools* [20, sec. 1007H]. See also *Pandie v Isaacs* [15, para. 91]. [↑](#footnote-ref-13)
14. See sections 2(2) read with sections 1 and 4. [↑](#footnote-ref-14)
15. See [23] as referred to in the Supreme Court judgment [1, para. 98]. [↑](#footnote-ref-15)
16. Studies in Latin America have indicated that in many cases of women living with HIV who are coercively sterilised, healthcare workers deliberately misinformed patients in order to coerce their agreement to the procedure (see [24]). [↑](#footnote-ref-16)
17. The extent of the undue focus on the ‘consent’ stage of the informed consent process is seen in the response of certain public hospitals in Namibia to the Supreme Court judgment. Following the judgment, a number of women have reported being denied voluntary sterilisation procedures and being told that they need to obtain police affidavits indicating their consent to the procedure before it is performed [25]. [↑](#footnote-ref-17)
18. The doctor testifying in relation to the sterilisation of the third respondent stated that sterilisation is normally performed 48 hours or 6 weeks after the patient gives birth [1, para. 83]. [↑](#footnote-ref-18)
19. See [26, p. 27] for a discussion on varying effects of pain during labour on a patient’s capacity to be informed for consent to epidural analgesia. [↑](#footnote-ref-19)
20. See the discussion of the 1972 case of *Canterbury v Spence* in [29]. [↑](#footnote-ref-20)
21. See *Castell v De Greef* [12, para. 425]. [↑](#footnote-ref-21)
22. See the discussion in [30, p. 313]. [↑](#footnote-ref-22)
23. Supreme Court judgment here cites the Health Professions Councils of Namibia’s Ethical Guidelines for Health Professionals [31]. [↑](#footnote-ref-23)
24. See the ‘Bolam’ principles as articulated in *Bolam v Friern Hospital Committee* [32]. See also *Sidaway v Governors of the Bethlehem Royal Hospital* [33]. [↑](#footnote-ref-24)
25. These principles in *Castell v De Greef* [12] were developed in reference to jurisprudence in Canada and Australia, including *Rodgers v Whitaker* [34] and *Riebl v Hughes* [35], in which the Bolam principles approach was rejected. [↑](#footnote-ref-25)
26. Supreme Court judgment [1, para. 107]: ‘I am not persuaded that the appellant has discharged its onus of demonstrating on the balance of probabilities that informed consent was given’. [↑](#footnote-ref-26)