REPORTABLE

CASE NO: I 1603/2008
CASE NO: I 3518/2008
CASE NO: I 3007/2008

IN THE HIGH COURT OF NAMIBIA

MAIN DIVISION, HELD AT WINDHOEK

In the matter between:

L M	**1ST PLAINTIFF**
M I	**2ND PLAINTIFF**
N H	**3RD PLAINTIFF**

and

THE GOVERNMENT OF THE REPUBLIC OF NAMIBIA	**DEFENDANT**

CORAM: HOFF, J

Heard on: 01 – 03 June 2010; 01 – 03 September 2010; 06 – 08 September 2010; 10 September 2010; 18 – 20 January 2011; 27 January 2011

Delivered on: 30 July 2012

JUDGMENT

HOFF, J: [1] The plaintiffs instituted actions against the defendant for damages which arose from what they allege in their respective pleadings to be an unlawful sterilisation performed on them without their consent by medical practitioners in the

employ of the State at State Hospitals, alternatively on the grounds of a breach of a duty of care that these medical practitioners owed to each of the plaintiffs.

[2] In a second claim each of the plaintiffs alleged that the sterilizations were done as part of a wrongful practice of discrimination against them based on their HIV status and that it amounts to a breach of their basic human rights as guaranteed by the provisions of the Constitution of the Republic of Namibia. It is not disputed that the HIV status of all three plaintiffs are HIV positive.

[3] The first claim is pleaded by the plaintiffs in similar terms and it is necessary only to refer to the first plaintiff's particulars of claim. The first plaintiff's particulars of claim reads, *inter alia*, as follows:

> "3. On or about 13 June 2005 and at Oshakati State Hospital, Oshakati, the plaintiff was wrongfully and intentionally assaulted, alternatively wrongfully and negligently caused harm in that she was subjected to a sterilization procedure, alternatively a sterilization procedure without her consent, by employees of the defendant, which caused her injury.
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> 4. In the alternative to paragraph 3 *supra,*
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> 4.1 At all relevant times the employees of the defendant referred to in paragraph 3 *supra*, had a duty of care to:
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> 4.1.1 Execute their duties without negligence;
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> 4.1.2 Not subject plaintiff to a sterilisation procedure, alternatively a sterilisation procedure without her consent and without explaining to her the concomitant or resultant risks and consequences flowing from, or incidental to, a sterilisation procedure;
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> 4.1.3 Take all reasonable steps to safeguard the plaintiff from being injured or from any loss or damages being occasioned to her;

4.1.4 Would take due and proper care of the plaintiff after her admission to, and at all relevant times whilst being a patient at, the Oshakati State Hopsital, Windhoek.

4.2 On or about 13 June 2005 and at the Oshakati State Hospital, Windhoek, plaintiff was subjected to a sterilisation procedure;

4.3 The aforesaid sterilisation procedure constituted, or resulted, from a wrongful and negligent breach of one or more or all of the duties of care set out in paragraph 4.1 above, which defendant as well as defendant's aforementioned employees at all relevant times had to and in respect of the plaintiff;

4.4 As consequence of the negligent breach of duty of care as aforementioned, plaintiff suffered injuries.

5. At all relevant times hereto, the aforementioned employees of the defendant acted within the course and scope of their employment with the Ministry of Health and Social Services and with the defendant, alternatively within the ambit of the risk created by such employment. The names and further particulars of such employees are unknown to plaintiff, save to state that they at all material times were personnel employed at, or attached to, the Oshakati State Hospital, Oshakati, Namibia.

CLAIM 1

6. As a result of the aforesaid sterilisation procedure and the conduct of defendant's employees referred to in paragraph 3, alternatively 4 *supra,* the plaintiff suffered the following violation and infringements of her common law rights and without derogating from the generality thereof, her common law and personality rights and more particularly

6.1 will be unable to bear children in future and found a family;

6.2 lost marriage prospects;

6.3 suffered and continues to suffer ongoing mental and emotional anguish;

6.4 endured and continues to endure shock, pain and suffering;

6.5 suffered and continues to suffer infringement of her rights to bodily and psychological integrity;

6.6 was subjected to torture or to cruel and inhuman or degrading treatment or punishment;

6.7 suffered and continues to suffer a violation of her dignity.

7. Alternatively to paragraph 6 *supra*, and as a further consequence of the aforesaid wrongful and unlawful conduct by defendant's aforementioned employees as set out in paragraph 3, alternatively 4 supra, plaintiff suffered a violation and an infringement of her rights guaranteed and protected under the Namibia Constitution, particularly:

7.1 Her right to life in terms of Article 6 of the Constitution;

7.2 Her right to liberty in terms of Article 7 of the Constitution;

7.3 Her right to human dignity in terms of Article 8 of the Constitutions;

7.4 Her right to found a family in terms of Article 14 of the Constitution.

8. As a result of the facts and circumstances as set out in paragraph 6 *supra,* alternatively paragraph 7 above, plaintiff suffered loss or damages (both past and contingent) in the amount of N$1 million. It is not reasonable nor practical to apportion the aforementioned globular amount of N$1 million to any of the numerous and particular infringements, violations and invasions of plaintiff's rights suffered by her as referred to in paragraph 6 and 7 above.

9. In as much as the aforesaid claim for loss or damages is based on what is set out in paragraph 7 above, plaintiff claims such loss or damages as monetary compensation in terms of Articles 25 (3) and 25 (4) of the Namibian Constitution.

CLAIM 2

10. The aforesaid sterilisation of the plaintiff by the defendant's aforementioned employees was a consequence of her being a woman who is HIV-positive.

11. As a result, the aforesaid sterilisation was a wrongful and unlawful practice of impermissible discrimination against the plaintiff.

12. As a consequence of the aforesaid wrongful and unlawful conduct, and particularly the impermissible discrimination as set out in paragraphs 10 and 11 *supra*, plaintiff suffered a violation and an infringement of her rights guaranteed and protected under the Namibian Constitution, particularly;

    12.1 Her right to life in terms of Article 6 of the Constitution;

    12.2 Her right to liberty in terms of Article 7 of the Constitution;

    12.3 Her right to human dignity in terms of Article 8 of the Constitution;

    12.4 Her right to equality and freedom from discrimination in terms of Article 10 of the Constitution;

    12.5 Her right to found a family guaranteed in terms of Article 14 of the Constitution.

13. As a result of the aforegoing, plaintiff suffered loss or damages and in entitled to monetary compensation in terms of Article 25 (3) and 25 (4) of the Constitution in respect thereof.

14. In the premises plaintiff is entitled to an award of monetary compensation by the defendant in the amount of N$200,000.00.

WHEREFORE plaintiff claims from the defendant:

Ad claim 1

1. Payment in the amount of N$1 million.

Ad claim 2

2. Payment in the amount of N$200,000.00.

Ad claims 1 and 2

3. Interest on the amounts as set out in prayers 1 and 2 above, at the rate of 20% per annum *a tempore morae* from date of judgment to date of payment.

4. Costs of suit.

5. Further or alternative relief ."

[4] Although the claims had been consolidated each of the different claims instituted by the plaintiff's has to be decided on its own merits as they relate to separate incidents.

[5] The defendant pleaded that in each case the plaintiff's written consent was obtained after the procedure was explained fully to the plaintiffs together with the risks and consequences thereof and also after alternative contraception methods had been explained.

[6] The issue in each claim is whether the defendant had obtained not only the plaintiffs' written consent but the plaintiffs' informed consent prior to the respective sterilisation procedures performed on them.

[7] It is common cause that all three plaintiffs underwent a sterilisation procedure which has rendered them incapable of bearing children.

[8] It was agreed between the parties that the question of liability be decided first by this Court and that the issue of quantum would stand over for adjudication at a later stage.

Applicable law

[9] The defendant's defence is the defence of *volenti non fit iniuria* in that the plaintiffs signed consent forms which signified consent to the sterilisation procedures.

[10] In *Castel v De Greef* 1994 (4) SA 408 (C) is regarded as a leading judgment on the issue of informed consent wherein Ackermann J (as he then was) with Friedman JP

and Farlam J concurring, made a paradigm shift from medical paternalism to patient autonomy. At 420A the doctrine of informed consent was placed within its common law context where the following appears:

> "It is important, in my view, to bear in mind that in South African law (which would seem to differ in this regard from English law) consent by a patient to medical treatment is regarded as falling under the defence of *volenti fit non iniuria,* which would justify an otherwise wrongful delictual act. (See, *inter alia, Stoffberg v Elliot* 1923 CPD 148 at 149 – 50; *Lymbery v Jeffries* 1925 AD 236 at 240; *Lampert v Hefer* NO 1955 (2) SA 507 (A) at 508; *Esterhuizen's* case *supra* at 718 – 22; Richter's case *supra* at 232 and *Verhoef v Meyer* 1975 (TPD) and 1976 (A) (unreported), discussed in Strauss (op cit at 35 – 6)).
>
> It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination."

[11] With reference to *Rogers v Whitaker* (1993) 67 ALJR 47, a decision of the High Court of Australia, the court in *Castel* stated the following at 426B:

> "Of particular importance is the conclusion of the Court in *Rogers v Whitaker* at 52 that:
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> '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 the therapeutic privilege.' "

[12] Therapeutic privilege referred to serves the purpose of protecting the patient's health not necessarily ensuring patient autonomy.

[13] In *Castel* at 425 the Court stated the following:

> "For consent to operate as a defence the following requirements must, *inter alia* be satisfied:
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> (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 consequence'."
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> (See also *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 173).

[14] It should be obvious that the required consent must be given freely and voluntarily and should not have been induced by fear, fraud or force. Such consent must also be clear and unequivocal.

[15] Carstens and Pearmain in *Foundational Principles of South African Medica Law* at 687 postulate that the "lack of informed consent amounts to an assault (in the context of wrongfulness/unlawfulness) and not negligence (in context of the element of fault). The concept of assault should not be assessed in its strict literal sense, but as a violation of a patient's right to bodily or physical integrity". These authors at 879 are of the view that since the patient is usually a layperson in medical matters, knowledge and appreciation on his or her part can only be effected by providing appropriate information. Adequate information becomes a requisite of knowledge, appreciation and consent and therefore also of lawful consent.

[16] In deciding whether or not the plaintiffs given informed consent prior to the surgical procedures this Court must consider whether plaintiffs had been provided with adequate information in order to enable them to make informed decisions.

[17] In Castel, with reference to F v R (1983) 33 SASR 189, a decision of the Full Court of the Supreme Court of South Australia, the following appears at 427A:

> "AJ King CJ considered in F v R at 192 (a passage approved in *Rogers v Whitaker* at 51):
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> 'What a caerful and responsible doctor would disclose depends upon the circumstances. The relevant circumstances include the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient?' "

Expert evidence

[18] Matti Kimberg testified that he is a qualified gynaecologist and obstetrician practicing in Windhoek. He holds an MB, B.Ch medical qualification being a fellow of the College of Obstetricians and Gynaecologists in South Africa and a fellow of the Royal College of Obstetricians and Gynaecologists in the United Kingdom. He has been practicing as a gynaecologist and obstetrician for more than 30 years. Prior to this he had been practicing as a general practitioner for eight years. He is Vice-President of the Medical and Dental Council of Namibia and serves on the Executive Committee of the Medical Association of Namibia.

[19] He testified that he regularly performs procedures at the Central State Hospital but do not work at the Katutura State Hospital and is not acquainted with the facilities at Katutura Hospital. In respect of the Central State Hospital there is an acute shortage of theatre space for a number of reasons and that the staff work under tremendous pace and pressure. He testified that he examined and consulted each one of the plaintiffs in his consulting rooms. Each one of the plaintiffs had given birth by way of a caesarean section, and a surgical procedure of bilateral tubal ligation (BTL) (performed on women to bring about sterilisation) had been performed on the plaintiffs.

[20] In respect of the first plaintiff the witness testified that he had on 20 April 2010 consulted with the plaintiff and a laparoscopy was done on 26 April 2010 at the Central Hospital. He found that the plaintiff had been sterilised and that the prognosis for a future reversal was poor. It was the plaintiff's third pregnancy at the age of 26 years of which the first child one was stillborn. The two previous pregnancies resulted in normal deliveries. From a perusal of the antenatal and maternity records there was little in the hospital records indicating what type of information was given to the plaintiff regarding the tubal ligation procedure and whether alternative methods of contraception were offered to her.

[21] It appears from a form "consent to an operation" that the plaintiff had signed and had given her consent for a "C/S due to CPD + BTL (ON HAART)" on 13 June 2005. Dr Kimberg testified that C/S means caesarean section and CPD is cephalic pelvic disproportion which means that the head of the child is either too big or in a wrong position or the pelvic too small to allow for a normal vaginal delivery. HAART means highly active antiretroviral therapy which means that the plaintiff was on treatment for her HIV condition. On the reverse side of this consent form is the doctor's report of the operation with a reference *inter alia* to the name of the patient and the signatures of two doctors and a nurse. This consent form is the standard hospital consent form and was the only form signed by the first plaintiff.

[22] In respect of the second plaintiff she was seen by him on 16 April 2010 at his consulting rooms and a laparoscopy was performed on her on 19 April 2010 at the Central Hospital. He found that the tubal ligation operation had severed the fallopian tubes very close to the fimbrial ends which gave a very poor prognosis for a reversal of the sterilisation. She gave birth to three children, two of whom were by way of caesarean section. The second plaintiff signed the standard consent form for an operation on 8 December 2007. On this form it is indicated that she gave consent for a "caesar + BTL

due to previous caesar". She also signed a second "consent form for sterilisation" in which she consented to undergo the "operation of tubular ligation, the nature of which has been explained to me. I have been told that the object of the operation is to render a patient sterile and incapable of parenthood". The form further states that plaintiff understands that if successful the procedure may be irreversible. At the bottom of this form there is a statement to be completed by a doctor to the effect that the doctor declares that he or she has explained the procedure and related aspects of sterilisation to the patient. This part of the form was not completed and not signed. This form also contains a section for a statement by the spouse of the patient which is optional. He testified that one would have expected the doctor to have signed this form, preferably earlier on in the pregnancy and in order to given the patient time to consider all her options. The witness testified that it is normally regarded that three caesarean sections are permissible because of the risk of the rupture of the uterus, bleeding and various complications with increasing caesarean sections. He also testified that on perusal of the hospital notes there is no record of the type of counseling that was provided and if alternative forms of contraception were offered. It further appears from the hospital records that a caesarean section was done due to prolonged labour which is a perfect valid reason for performing the caesarean procedure since prolonged labour in an HIV positive patient increases the incidence of mother-to-child transmission.

[23] In respect of the third plaintiff consultation was done on 27 April 2010 at his consulting rooms and a laparoscopy was carried out on 3 May 2010 in the Central Hospital. The third plaintiff was 46 years old and had 6 normal deliveries and one caesarean section. The witness testified that from a surgical point of view the prognosis for reversing the sterilisation was good but the chances of another pregnancy would not be good at all due to the age of the plaintiff. The third plaintiff signed the standard form of consent to an operation on 13 October 2005. It appears from this form that she consented to a caesarean section due to prolonged first stage and BTL. The third plaintiff

also signed a second consent form for sterilisation on the same date. The statement at the bottom of this form was completed and signed by Dr Sichimwa on 13 October 2005. It appears from the hospital records that when she was in labour for natural birth, there was no booking for her for a sterilisation procedure. There was nothing in the health passport of the plaintiff that she was to have a sterilisation procedure.

[24] The witness testified that the pain experienced during labour by women can be extremely intense and can become so overwhelming that they virtually loose sense of reality. They are not aware of anything else except this awful pain. He testified that the circumstances under which to secure the consent of a patient in respect of a sterilisation procedure is when the patient is rational and not in pain, has time to consider it, time to discuss it with her partner and relatives and thereafter come to a reasoned conclusion. It is not a decision to be taken under the duress of extreme pain.

[25] Dr Kimberg testified that in reaching informed consent certain factors should be taken into account:

(a) understanding the information relevant to the decision and being able to retain and assimilate that information;

(b) being able to weigh that information as part of the process of making that decision;

(c) being able to properly communicate that decision;

(d) being aware of the short and long term possible repercussions of the decisions;

(e) being aware of and able to evaluate the alternative options available, if any, and after having been duly informed of such alternatives;

(f) not being subject to undue influence by the situation, environment and coercion by medical personnel (commonly referred to as medical paternalism) and/or other parties; and

(g) being advised of the ability to withhold consent, even if it might not be in her best interest to do so and the need to respect that decision.

[26] In *Foundational Principles of South African Medical Law supra* the authors with reference to *van Oosten LLD Thesis 4*58 stated that the patient's right to informed consent is not absolute and that the needs and contingencies of medical practice sometimes, depending on the circumstances, place restrictions on the duty to disclose information. One of such restrictions is where the patient is already in possession of the requisite information.

[27] The onus of establishing the defence of *volenti non fit iniuria* rests on the defendant. (See *Santam Insurance Co. Ltd v Vorster* 1973 (4) SA 764 (A) at 779 A – B). In the law of delict the onus to prove the existence of a ground of justification (*in casu, volenti non fit iniuria*) rests on the defendant. (See *Mabaso v Felix* 1981 (3) SA 865 (A); *Ntamo v Minister of Safety and Security* 2001 (1) SA 830 (TK) at 833 A; *Ferreira v Ntshingila* 1990 (4) SA 271 (A) at 273 A).

[28] Whether or not informed consent was present is a factual issue and not a legal one.

[29] Dr Kimberg testified that it is important to record the fact that alternative contraception methods have been discussed especially in a hospital situation because a patient may be seen by different doctors at different times, by different nurses and one does not have the advantage of getting to know the patients and their circumstances. In these instances the patient would be responsible to take the decision herself and needs to be fully informed as to what her options are.

[30] It was his evidence that assuming the three plaintiffs had received counseling and options had been explained he would have hesitated to do a sterilisation in those circumstances because there are very acceptable long term methods of contraception which can be instituted at the same time of the caesarean section without any problems e.g. an intra-uterous device, and that it was not necessary to do what could be an irreversible operation if there is doubt at all in the mind of the physician. Such doubt would be present where the patient signs the consent form under the duress of a painful, unstable, disturbing condition, which is the painful labour. Sterilisation could be done around the six week check-up when the patient comes back, through a laparoscope, which is a one-day procedure. According to Dr Kimberg it has the disadvantage that the patient would be subjected to two operations, but it would at least ensure that by the time the patient actually signs for the sterilisation, she is in a rational state of mind and has had the time to think about it.

[31] Dr Kimberg agreed with certain guidelines contained in literature discovered by the defendant to the effect that the principle of informed consent must be applied as an ongoing process; that it is compulsory in keeping proper record and the prescribed information which needs to be recorded; that in the case of litigation no record equals no defence; that records should be complete, but concise and in chronological order; that the disadvantages of tubal ligation is that it is very expensive to try to reverse; that tubal ligation is not the best method for a woman who is single and has not had a child or still wishes to have more children; that there should be unhurried and skilled counselling as an essential prerequisite to any sterilisation procedure, it should take place without pressure in a language that is clearly understood; that woman aged 30 years or less at the time of the operation are more likely than an older woman to be dissatisfied and would seek a reversal often because their domestic circumstances have changed; that a record should be kept of what the patient was told of possible risks and the instructions

given to the patient; and that the decision to be sterilised should have been taken before or during pregnancy to avoid the risk of a rushed decision that may be regretted later.

[32] Dr Kimberg conceded during cross-examination that mistakes certainly occur during the recording process and are more likely to occur if somebody is overworked, stressed and working under a lot of pressure but that there are certain vital information that have to be recorded such as the details of counseling and information that has been is given to a patient. Dr Kimberg, when it was put to him that State patients do not sign consent forms when they consult with doctors (as is the accepted practice testified by Dr Kimberg in private practice) but *sign* a consent form when such a patient is being prepared for surgery at the State Hospital, replied that it seems to be an acceptable procedure as long as there has been a prior explanation. It was put to Dr Kimberg during cross-examination that it is the defence's case that every pregnant woman who goes to Katutura Antenatal Clinic is provided with antenatal care and as a subsidiary of that antenatal care, family planning is provided when contraception is discussed with patients in groups and in the language of their respective preferences, including sterilisation and alternatives. He replied that patients should or actually need individual counselling.

First Plaintiff

[33] It is common cause that the first plaintiff gave birth by way of an emergency caesarean section on 13 June 2005 at the Oshakati State Hospital because she was diagnosed with a condition known as cephalic pelvic disproportion (CPD). A sterilisation procedure was performed at the same time on the plaintiff. At the time the procedures were performed the first plaintiff was 26 years old. She had two previous pregnancies and delivered normally though her second child was stillborn. She completed Grade 10. Her home language is Oshiwambo. The first plaintiff tested HIV positive in 2004 when she attended a health facility in Grootfontein. Her first of several antenatal care visits to

the clinic was on 5 January 2005. According to her there was no discussion about the concept of sterilisation and its applicability to her. On 9 June 2005 she went to a clinic at Ongwediva for an antenatal care visit where she discovered that she was discharging blood in the waiting room. She was taken to Oshakati State Hospital where she was informed that there was no dilation and was told to come back 4 hours later. On 10 June 2005 at about 20h23 she had pain, not severe and there was dilation. On 11 June 2005 she had contractions and stayed in the vicinity of the hospital in the waiting area. On 12 June 2005 her contractions were severe and she was in pain. On 13 June 2005 she experienced severe pains. She told the hospital personnel that she was unable to walk and was told to lie down. She was then seen by a male doctor who examined her and told her that she cannot deliver because she was very exhausted. The doctor instructed a nurse that plaintiff be taken to the theatre to undergo a caesarean section. The doctor spoke English. A nursing student translated. The doctor did not mention anything about sterilisation to her. She testified that before she could be taken to the theatre a nurse came into the delivery room and told her that she will be sterilised since all women who are HIV positive go through that procedure. The nurse then brought documents for her to sign. She did not know whether the documents were in respect of her consent to undergo the operation or whether it was in respect of consent for sterilisation. She was given these forms when she was on a stretcher just before she went into the theater. The nurse did not explain anything about the procedures she would be undergoing. It is common cause that she signed only one document where she consented to “c/s due to CPD and BTL”. She did not know what caesarean section or the other acronyms on the consent form meant. She testified that the way the nurse conveyed the information to her sounded forceful, and that it was “a compelling thing”. She testified that she was in severe pain and no alternatives to the procedure were explained to her by the hospital personnel. She did not ask the nurse any questions since it sounded that the nurse was forcing her. She only discovered afterwards that she had been sterilised. She testified that she felt very bad as a result of the procedure

because in her culture if a woman is unable to give birth then her in-laws might tell her that the husband should divorce or desert her.

[34] When it was put to her during cross-examination that both Dr Mavetera and nurse Angula will testify that she requested sterilisation and was made aware at that stage that the procedure is irreversible and that she would be unable to bear any children, it was denied by the plaintiff. She disputed that she actually used the Oshiwambo word for sterilisation when she requested it. She denied that Dr Mavetera explained to her that the reason for the cesarean section was because of her condition namely that the baby's head was too big to pass normally through her pelvis. The plaintiff denied that a nurse translated to her stating that it was a student nurse. She testified that she could read English but was not asked to read the consent form but believed that she signed the form to consent only to the removal of her child. She testified that it was not her intention to be sterilised and that she did not give consent for sterilisation.

[35] Innocent Mavetera testified that he qualified as a general practitioner in 1995 and as a specialist in obstetrics and gynaecology in the year 2000. He testified that he was called by nurse Angula to review the plaintiff. He examined her and found that the membranes were ruptured and the head of the baby could not fit the pelvis and that she would not have a normal delivery. He established that the plaintiff was on highly active antiretroviral treatment (HAART) after talking to her. He ordered a caesarean due to CPD plus BTL. He testified that he explained to the plaintiff that since she cannot deliver on her own she was going to the theatre to be operated on and to remove the baby. He testified that after he had explained this the plaintiff decided that "she also wants to be closed". Since "closing patients" is not a routine, especially when they come for caesarean section he explained what sterilisation means and what her future chances are of having children. The nurse would be translating and the patient would later give consent after she has understood what was explained and the patient would then sign the

consent form. He testified that the plaintiff was there for 14 to 15 hours in the hope that she would deliver normally. According to him he would not have performed a sterilisation if the plaintiff had no previous children, but since it was her second live birth he thought it reasonable enough to do the procedure. He testified that plaintiff would normally have decided on sterilisation during antenatal care because sterilisation is a method of contraception and normally contraception is discussed at the antenatal clinic. He stated that the plaintiff did not sign the consent form in his presence. In respect of a second consent form dealing specifically with sterilisaiton he testified that at that stage they never had it at the hospital and that the consent form singed by the plaintiff was the standard form they used for all procedures. He agreed that under normal circumstances it is highly undesirable to use acronyms on consent forms but the circumstances under which people work at State Hospitals are not normal e.g. a doctor would see 50 to 90 patients a day. In respect of the acronyms he testified that they are used in the health passport because it is for fellow health workers to read and understand. He further testified that because of their workload and shortage of personnel "most of the things what we talk to our patients … we do not write down". He testified that he had no independent recollection of the plaintiff given the large number of patients he dealt with and because of the effluction of time, and gave his evidence only with reference to his notes. He conceded during cross-examination that even though the use of acronyms on hospital records, like health passports, may be primarily for the benefit of health officials, the use of acronyms on *consent forms* is highly undesirable even more so in the case of an invasive procedure such as a sterilisation. The witness conceded that nothing appears in the health passport of the plaintiff to suggest that the sterilisation procedure had been canvassed.

[36] Victorina Uuso Angula a registered nurse and midwife who worked in the maternity ward for over 18 years prepared the plaintiff and signed as a witness on the consent form. She confirmed the plaintiff was informed of the reason why the plaintiff had to undergo a caesarean section and testified that it was at that stage that the plaintiff said

she wanted to be sterilised after the doctor had explained it to her. She testified that she herself had also explained the contents of the consent form to the plaintiff. She conceded that her notes did not record this explanation and that it was a mistake made, and that due to the urgency of the operation did not complete fully the medical record of the plaintiff.

[37] It is clear from the evidence of both Dr Mavetera and nurse Angula that they *assumed* that the plaintiff knew what sterilisation was and that she understood the consequences because she had attended antenatal classes where they also *assumed* plaintiff was informed of all aspects concerning sterilisation.

[38] It was submitted by Mr Smuts who appeared on behalf of the plaintiffs, that this assumption relied on was plainly for the purpose of dispensing with the need for a proper explanation of the procedure and its risks and alternatives to it.

[39] Dr Mavetera conceded during cross-examination that he should rather have advised the plaintiff to come back for sterilisation after 6 weeks. He stated that that is what they would normally do but couldn't recall whether it was done in this case. Nurse Angula's response to the same question was that a sterilisation can be done at any time and asked why should the plaintiff be sent away just to be operated on for a second time. It must, in the light of this response be accepted that plaintiff was not advised to return after six weeks. If this was indeed normal procedure nurse Angula would have said so.

Second Plaintiff

[40] The second plaintiff gave birth by way of a caesarean section on 9 December 2007 at Katutura State Hospital, Windhoek. At the same time a sterilisation procedure was performed on her. She completed Grade 12 in Ondangwa and is able to read, speak

and understand the English language. She has three children aged 17 years, 9 years and 3 years respectively. She was diagnosed HIV positive in 2007 when she fell pregnant. She testified that the counselling that she received was given by volunteers at the Red Cross, but none from the nurses. The counselling related to pregnant women knowing their HIV status and the importance of the unborn baby be protected against the virus. She testified that no further counselling was done but she continued to attend the antenatal care clinic – only to check the progress of the pregnancy. She testified that on 6 December 2007 she went to an antenatal care session and that the nurse who examined her found that the head of the baby had not turned downwards and referred her to a doctor. The doctor confirmed that the foetus was in a breach position. It appears that the doctor who examined her was Dr Gurirab. The doctor advised her that she gives birth by way of caesarean section because she had given birth to her second child through a caesarean section and because of her HIV positive status. The doctor also informed her that she would be sterilised and that she should agree to that. She was informed that she would not be able to give birth in future. The doctor did not ask her whether she wanted more children or whether she wanted to consult with family members or friends. She did not receive any counselling about sterilisation and was not informed of the advantages and disadvantages of sterilisation. She testified that she was not asked whether she wanted to be sterilised and was told by the doctor that she was going to be sterilised whether she wanted it or not. The manner in which the doctor spoke made her afraid since he spoke in a “forceful manner”. She testified that although she did not want to be sterilised she did not ask questions because she was informed that if she did not agree to the sterilisation he would not book her for the caesarean section. On 8 December 2007 plaintiff started having contractions. Between 19h00 and 20h00 these contractions became severe and she asked her boyfriend to take her to hospital. She was admitted about 23h00. She was in severe pain. She was laid on a bed. Nurses came to observe her and later a nurse came to her with papers or documents and with an intravenous drip. When she enquired about the purpose of the document the nurse

informed her that the doctor had already explained it to her and that she only had to sign. The nurse hurried her to sign the documents. In respect of the second consent form, plaintiff denied that she wrote her name on the consent form. She confirmed that she signed both consent forms at the same time. She testified that she knew what a caesarean section was but that she did not know what BTL meant, and that none of the contents on the form was read to her. She was only told to sign. She testified that the nurse was in a hurry and she herself did not read the contents of this form. She did not know or understood that she was sterilised but only became aware of it six weeks after the operation when she came for a check up. She testified that when the doctor told her she was going to be sterilised she knew the meaning of the word because she had read about it but that it was not explained by either the doctor or the nurse. She testified that she was made to understand that there is a policy in place that women who are HIV positive should be sterilised. No basis was provided for this understanding.

[41] Quincy Gurirab a medical practitioner graduated a the end of the year 2006 from the University of Pretoria and started working for the Ministry of Health and Social Services in January 2007. He did not have an independent recollection of who the patient was and relied on his notes made in the antenatal care passport. He saw the patient on 6 December 2007. He recorded certain information and that the patient was booked for elective caesarean section due to a breach presentation and this was also recorded. He testified that he *would have* explained to her what caesarean section was, the advantage, and disadvantages, and would have made sure that she understood it. He would have explained to her that sterilisation is a surgical procedure with its own inherent risks with regard to anaesthesia and the procedure itself. This explanation is however not reflected in the antenatal care record. During cross-examination he conceded that there was no inscription in the passport that alternatives to sterilisation had been explained to the patient. He testified that since he did not note BTL in the passport

he was of the view that he did not mention it to the patient. He testified that it was unlikely that he would have raised the issue of a sterilisation with the patient.

[42] Even Maria Ndjala is registered nurse who qualified as a midwife in the year 1986. She testified that she prepared the second plaintiff for her operation and also obtained her signature on the two consent forms. She testified that she would have explained to the plaintiff that she was going to be sterilised and would be unable to have any children in the future and that it was irreversible. She would have asked the plaintiff whether she understood and once she had agreed she would have given her the forms to complete after she had given an explanation to her. She testified that plaintiff wrote her name on the forms and signed the forms. Her response to a question why she has given the explanation whilst the plaintiff was in labour, was that labour is not continuous and that she would have explained during the intervals when there were no contractions and would stop when the patient was having a contraction.

[43] Nurse Ndjala admitted during cross-examination that she read the plaintiff's antenatal care record and when she saw the inscription "BTL" and another inscription where there is reference to "Family plan: BTL" she assumed that the plaintiff wanted to be sterilised and that plaintiff had already been counselled. She admitted that the instruction given to her by the doctor on 9 December 2007 was to prepare the patient for a caesarean section only. She testified that because of her assumption that the plaintiff had already been counselled she did not consider it necessary to counsel her again. She testified that she needed to obtain confirmation from the plaintiff that she would still want to have a sterilisation. She denied that she compelled or coerced the plaintiff into having a sterilisation. It was put to her that the plaintiff's evidence was that she was told that she would have to have a sterilisation because she was HIV positive, to which nurse Ndjala responded that she has never heard of a person being sterilised because she is HIV positive.

[44] Celest de Klerk a general practitioner qualified at the medical school of the University of Cape Town in the year 2003. She worked as a medical officer in the Katutura Anti-Retroviral Clinic from 2004 until the year 2009. On 26 October 2007 she saw a female patient, the second plaintiff. She testified that she made notes, *inter alia*, one on the outer cover of the antenatal care record card where there is an inscription "BTL". She describes that a description "Family plan – BTL" indicated that the plaintiff "opted" for a sterilisation as a method of family planning after the birth of her child. She testified that she would have discussed family planning in general in layman's terms and would have referred to different options including sterilisation. If the patient opted for sterilisation she would have made the inscription as it appears on the antenatal care record of the plaintiff. She wrote "BTL" on the cover of the antenatal care record to draw the attention of personnel at the antenatal care clinic because the two clinics are different and there for different purposes. She testified that she made it clear that the plaintiff would still have time to go home and consider the chosen option.

[45] It was put to Dr de Klerk during cross-examination that the inscription may be interpreted differently by another health official as meaning that it is something which was merely raised with the patient or recommended to her and would not necessarily be read as an accepted option. Dr de Klerk, after much debate, conceded that an indication regarding family planning would not necessarily be considered as final consent by the patient. She also acknowledged and accepted the fact that the patient may have opted at the time for sterilisation as a family planning method cannot be relied on for purposes of claiming that she had given her informed consent to the sterilisation procedure.

[46] Dr de Klerk testified that she gave the patient information about family planning, and that issues like how the procedure for bilateral tubal ligation is done, what the risks are involved, what the consequences of the procedure would be, the possibility of a reversal, would not have form part of the discussion with the patient

Third Plaintiff

[47] The third plaintiff was born on 10 October 1964. She is not married and has six children from eight pregnancies. She reached standard 5 at school. She has three children with her current partner, a married man, with whom she has had a relationship since 1990. The plaintiff was diagnosed with the HIV virus in the year 2002.

[48] On 10 March 2005 when she was about three months pregnant she was experiencing severe pain to the extent that she felt like she was going to die as a result of the pregnancy. She was unable to walk and had to be carried by her partner to the car and thereafter had to be wheeled into the hospital on a stretcher.

[49] She testified that she requested that the pregnancy be terminated ("removed") because she feared that she was going to die. It is not clear what she meant by the removal of the pregnancy because she also testified that her "intention was not really for the child to be removed from my stomach, only for that to be rectified by the doctors".

[50] She was examined by more than one doctor and was also taken for a sonar. She testified that the conversation that took place between the health professionals amongst themselves and at some point between the health professionals and her partner was conducted in English which she could not understand. Her partner eventually told her, pointing to the sonar, that the doctors said that the baby is too big, that they cannot terminate the pregnancy, and that she had to come for treatment.

[51] In a referral note written by Dr Ithete on 10 March 2005 it was stated that plaintiff, 40 years old, requested a termination of her pregnancy on medical grounds.

[52] The plaintiff testified that she attended the antenatal care clinic on 4 May 2005. In respect of an inscription “elective c/s + BTL” plaintiff stated that it was not discussed with her and that she did not consent to it. On 12 October 2005 contractions started, and she took a tablet called Neverapine, as instructed, and went to Katutura State Hospital where she was examined by a nurse who wrote something in her passport. She was in pain. She was informed to go somewhere and walk but was unable to do so because of severe pain. The nurse later returned with a doctor who examined her. After the doctor left a nurse returned with a paper in her hand and told her to write. The nurse told her in Oshiwambo to write her name (“shanga”) and repeated in Afrikaans “skryf, skryf”. The plaintiff testified that she put her name on the piece of paper whereafter she was told to get onto a stretcher and was wheeled into a white room with big lamps. She testified she did not understand anything contained in the documents. She confirmed that she wrote her name on the two consent forms and that she signed one but because the writing on the second form (consent form for sterilisation) was faint she did not acknowledge that it was her signature but did not exclude the possibility that she signed it. She testified that she contemplated normal delivery because she gave birth to her other children naturally. At some stage after the operation she overheard two nurses speaking in Oshiwambo that she had been closed.

[53] Erica Kamberipa Tjimbundu a registered nurse qualified as a midwife during the year 2004 and started working at Katutura State Hospital, the next year. She admitted the plaintiff to hospital and recorded certain information. The plaintiff complained of severe backache. She was not sure which language was used but thought that they communicated in Oshiwambo. She made an inscription “patient prepared for caesarean section and BTL, consent signed by patient herself after the doctor explained the operation to her and she signed”. She explained that the consent for sterilisation form is explained to the patient by the doctor and the doctor and patient would sign the form. The standard procedure is that if a patient does not understand a certain language an

interpreter would be used. She testified how antenatal care is provided at the State Hospital and that it is done in different languages.

[54] She testified that the next set of inscriptions made in the maternity record were made by a doctor. The plan was to allow the labour to progress and keep the membranes intact for sterilisation at a later stage. It appears from subsequent evidence by Dr. Sichimwa and Dr Kronke that the doctor who made these inscriptions was Dr Fong who was on duty during that evening. He was not called to testify.

[55] Nurse Tjimbundu testified that inscriptions made on 13 October 2005 at 08h35 were made during a ward round with the consultant who was Dr. Kronke. It appears from the notes that she was diagnosed as being in prolonged first stage of labour and the plan decided by the doctor was for her to undergo a caesarean section due to the prolonged first stage and sterilisation. Dr Sichimwa testified that Dr. Fong made these inscriptions and also confirmed that it was decided by the *doctors* that she must have a caesarean section and a sterilisation.

[56] Nurse Tjimbundu testified with reference to the consent form for sterilisation that her experience was that the standard procedure was that the doctors are the ones taking decisions. The procedures would first be explained to the patient before she signs for the operation. She confirmed during cross examination that it was the decision of the doctor as to what was going to happen to this patient. She further testified that the doctor should also sign the consent form to sterilisation. She testified that when the plaintiff was admitted she assumed, based on the notes contained on the front page of the ante-natal case record, that the plaintiff had already agreed to a sterilisation and that she did not have to discuss this issue with the plaintiff since it was indicated on the ante-natal case record that the plaintiff had accepted to be sterilised. She testified that it must have been

Dr. Sichimwa who explained the sterilisation procedure since he signed the declaration at the bottom of the consent form for sterilisation.

[57] The notes in the maternity record do not explain which doctor explained the sterilisation procedure to plaintiff or what was explained to her. Nurse Tjimbundu testified during cross examination that family planning provided at group sessions at ante-natal classes would not constitute counseling in any proper sense and individual counseling is still required. She testified that during these sessions the patients are only shown the different methods which are available and if a patient indicates during an ante-natal care class that she wants a sterilisation, she would be referred to a doctor for proper counseling. This she confirmed during re-examination.

[58] Godfrey Sichimwa qualified in the year 2004 from St Georges University in the West Indies as medical practitioner and thereafter pursued post graduate studies at the University of Witwatersrand in 2009 with the aim of becoming a specialist obstetrician and gynaecologist. During August 2005 he took up the post of medical officer within the Ministry of Health and Social Services at Katutura State Hospital. On 13 October 2005, he was on duty as medical officer. From inscriptions in the maternity record it appears according to his testimony that the plaintiff had a planned operation for a caesarean section and bilateral tubal ligation but somehow did not turn up to be given a date for the operation. She was in early labour and the plan was to allow labour to progress and for a bilateral tubal ligation to be done at a later stage.

[59] On 13 October 2005 at 08h35 when ward rounds were done by Dr. Krönke, he was present. He testified that due to the prolonged first stage of labour a caesarean section would have been offered to the plaintiff and that in view to her age, the number of children she had, and her retroviral status, a bilateral tubal ligation would have been offered again since it had already been offered in terms of the health records of the

plaintiff. He testified how he would have explained a caesarean section and a sterilisation procedure to a patient, the risks involved, the nature of the operations, how the procedures are done and that sterilisation is one of the most effective contraceptives available. These would have been explained in layman's terms and in a language which the plaintiff understands.

[60] In respect of the consent to sterilisation, he confirmed that he signed the declaration at the bottom of the form and stated that by virtue of his signature it means that he would have been the doctor who had explained the procedure to the plaintiff. He testified that the patient would sign this form in the presence of the doctor but that it is possible that a nurse will obtain the signature of the patient after the doctor had explained everything to the patient. Once a patient has signed the form the patient would be prepared for the theater.

[61] During cross examination, Dr. Sinchinwa conceded that he is not able to state precisely what he did with the plaintiff and that for recollection he relied on his notes due to the large number of patient that are seen at the state hospital (roughly 500 deliveries per month). He does not have any recollection apart from his notes what specifically was said to the plaintiff. He testified that he himself, Dr. Fong, and an intern were present with Dr Krönke at 08h35 when an assessment was made by the consultant, Dr. Krönke. Nursing staff were also present. He testified that when the inscriptions were made at 08h35 by Dr. Fong, would have been the time the explanation had been received by the patient from the doctors. He testified that though prolonged labour may be the underlying reason why a caesarean section would be performed, a sterilisation would not be effected for that same reason. He disputed that the plaintiff did not understand what was explained to her and stated that he himself explained the procedure to the plaintiff. Dr. Sichimwa admitted that from the medical record of the plaintiff, no reason was indicated why she had to undergo a sterilisation procedure. He further admitted that as the

surgeon who performed the operation that it was his responsibility to be satisfied that the plaintiff had properly consented to the operation and that a proper note should have been kept in this regard by him. His explanation for failing to make any notes was that the stationery used by the health professional at the State hospital did not provide space for pre-operational notes, only for post-operational notes but added that it is not a requirement for a surgeon to make notes before doing the operation. He admitted that there was no note by a medical officer that the plaintiff had consented to a caesarean section. He however stated that there is a note on the consent form for an operation for caesarean section, which form was signed by Dr Fong and that it was Dr Fong who had explained the procedure to the plaintiff even though Dr Fong did not perform the operation. He admitted that Dr Fong doesn't speak Oshiwambo. Dr Sichimwa stated that the possibility was that Dr Fong explained the caesarean section procedure to the plaintiff and that he explained the sterilisation procedure. He also admitted that there was an obligation on him to explain alternative contraceptive methods to the plaintiff. He agreed that a patient should have been provided with an explanation regarding the sterilisation procedure, the alternatives and that this should have been recorded. The reasons given for the sterilisation were that the plaintiff was at that stage over 40years old, her retroviral status and her multiple pregnancies. These reasons according to Dr Sichimwa were provided to the plaintiff which he covered within a period of ten minutes with the aid of an interpreter. He admitted that informed consent is an ongoing process of which an important aspect is to inform the patient that she may withhold consent. He however could not recall whether he informed the plaintiff that she may withhold her consent to the sterilisation procedure. Dr Sichimwa agreed that in terms of Ministerial policy unhurried and skilled counselling is an essential prerequisite to any sterilisation procedure. Dr Sichimwa agreed during cross-examination that the decision that the plaintiff undergoes a caesarean section was a "sudden decision". It was also agreed that the decision that the plaintiff should undergo a caesarean section was a collective decision taken by himself, the consultant Dr Krönke and Dr Fong. It was put to Dr Sichimwa that

the caesarean section might have been *offered* to the plaintiff but that it was the *decision* of the medical professionals what should happen to the plaintiff. He responded that the plaintiff was part of the decision making process.

[62] Tshali Iithete a medical doctor and a medical superintendent of the Ongwediva Medical Park in Ongwediva in northern Namibia testified that he qualified as a medical doctor in the year 200 from the University of Natal, Durban, in South-Africa. He is Oshiwambo speaking. During the year 2005 he was employed by the Ministry of Health and Social Services as a medical officer at Windhoek Central Hospital as well as Katutura State Hospital. He testified in respect of a referral letter written by him on 10 March 2005 regarding the third plaintiff. The letter was addressed to his colleagues and *stated inter alia* the following:

"I have discussed at length with both patient and partner about current legislation (Namibia) on termination of pregnancy and suggested PMTCT (which stands for prevention of mother to child transmission) and possible elective hysterectomy; also discussed for them to practice barrier method contraceptive as husband still negative. Could you please kindly assist whether T.O.P (termination of pregnancy) on medical grounds is an option at all and … regards Dr T Iithete."

He recalled the case because plaintiff was one of the first patients with HIV requesting termination of pregnancy on medical grounds. He testified that he spoke to the plaintiff in Oshiwambo. He testified that what appears in the referral letter was discussed with the plaintiff. He stated that he referred the patient to the department of gynaecology to be seen by the health officials there on 30 March 2005. The plaintiff was booked for this date. He testified that the plaintiff did not express anything about feeling unwell. He testified that the plaintiff came there with her partner related her past experience and requested a termination of pregnancy based on her past "pregnancy experiences" and the previous loss of a baby due to HIV, and that the plaintiff did not necessarily request the termination of pregnancy on the basis of her medical condition. Dr Iithete testified

that both the plaintiff and her partner spoke to her. Dr Iithete testified that the issue of elective hysterectomy was raised because of the plaintiff's previous history of severe bleeding.

[63] Dorothea Maria Krönke, a witness called by the defence qualified as a medical doctor in 1985 in Germany. She started to work in Namibia at the State Hospital from 1987 until 1992. She returned to Germany where she qualified as a specialist gynaegologist and thereafter returned to Namibia where she worked at the Central Hospital as well as Katutura State Hospital.

[64] She testified that in 2005 the antenatal clinic was run by sisters and nurses who were specially trained for antenatal care and that there were regular group counselling. During the group counseling different forms of contraception are discussed including sterilisation. When she has a discussion with a patient who does not understand English she would make use of an interpreter. The third plaintiff arrived at the hospital on 13 October 2005 at 18h50 when she was in early labour. The plaintiff previously requested a termination of pregnancy on medical grounds. The plaintiff has previously been observed by Dr Kheiseb, the Head of the Department. The pregnancy was too advanced for the termination thereof. The plan was to have an elective caesarean section and a sterilisation. Her experience was that the maternity ward at Katutura State Hospital was very busy with around six thousand deliveries annually. In respect of the antenatal care record of the plaintiff it was indicated in front of the document: "wants BTL". The third plaintiff was seen by Dr Fong the previous evening who still had the hope that she might deliver normally. The next morning this plan was reviewed and it was decided that she had to undergo a caesarean section. It was recommended to the plaintiff that a sterilisation be done simultaneously and that this was discussed with the plaintiff. She testified that a patient should not be counselled for the *first* time while she is in active

labour regarding the option of sterilisation. She testified that in her capacity as a consultant she herself was not involved in obtaining informed consent from the plaintiff.

[65] Dr Krönke, in response to a statement during cross-examination that when it comes to sterilisation counselling it must be done on a one-on-one basis, stated that such sterilisation counselling is being done during group counselling where all types of contraception are discussed, where each and every contraception method is presented and this is regarded as sufficient if a patient understands what has been conveyed to her. Should a patient need further individual counselling that would be arranged. She testified that there are simply too many patients at the antenatal care clinic to counsel each and everyone on a one-on-one basis. Dr Krönke, in response to a statement during cross-examination that the people who attend the group counselling and the antenatal clinic would be at different levels of education and experience, stated that at these group counselling sessions the health officials presume that the patients are at a low educational level (since that was their experience) and counselling is being done in very clear and simple words for everyone to understand. She further testified that the health officials are experienced in dealing with the group counselling on this basis. Her testimony in respect of the third plaintiff was that she requested a termination of her pregnancy and never mentioned acute pain or other problems as the reason for wishing to terminate the pregnancy. If this had been the case she would have examined the third plaintiff, would have recorded it and would have changed the management immediately and completely. Apart from being HIV positive, being elderly and being a high risk pregnant patient, third plaintiff was found to be otherwise stable and healthy. A caesarean section and a sterilisation was recommended to the patient when she was three months pregnant and had plenty of time to weigh her options. It was put to Dr Krönke that if third plaintiff had understood that what was involved was a sterilisation she would have made a booking for such a procedure. Dr Krönke disagreed. She testified that under these circumstances a booking would normally have to be made for a caesarean section,

the sterilisation being additional to that but the fact that a booking was not made does not necessarily indicate that the patient did not want the sterilisation since from her experience there are a number of reasons why patients do not make bookings. Dr Krönke further testified that it is not the common practice, and it is impractical to send out reminders to patients when they do not adhere to their appointments due to the sheer number of patients that are seen. She testified that it often occurs that no booking has been made but a patient would come at a time when it is necessary to do the surgical procedure. The third plaintiff was booked for an elective caesarean section due to her advanced age, the number of her previous deliveries, her HIV status, and because of her prolonged labour. Dr Krönke conceded during cross-examination, that there was no consent given for sterilisation by the third plaintiff in discussion with herself (i.e. Dr Krönke) and that there is no indication in all the hospital records that plaintiff had given consent at any time before she was in hospital and shortly before her surgery.

Evaluation of Evidence

[66] It is common cause that the plaintiffs underwent sterilisation procedures and it is not disputed that the required consent is more than just written consent, but *informed* consent. It is furthermore also not disputed what information should be made available to a patient in order to put such a patient in a position to make an informed decision.

[67] The defendant's medical personnel accepted that it is a surgeon's legal duty to obtain informed consent from a patient although a registered nurse may be requested to procure the patient's signature on the consent form. This is also in accordance with the ethical standards governing health professionals, as set out in the guidelines for them issued by the professional councils.

[68] In respect of the first plaintiff it is common cause that the plan was that she would deliver naturally. The plan changed when she was diagnosed with CPD. The first plaintiff's case is that she had no intention to have a sterilisation. It is common cause that the plaintiff did not signed any form dealing specifically with sterilisation. Dr Mavetera had no independent recollection of what was said to the plaintiff and had to rely on his contemporaneous notes. Dr Mavetera conceded that there was no contemporaneous record of any request by the first plaintiff or any expressed intention on first plaintiff's part to have a sterilisation in any of her medical records. Registered nurse, Angula who had testified that she herself also explained the contents of the consent form to the plaintiff also conceded that her notes did not record that she had given this explanation. Both Dr Mavetera and nurse Angula assumed that plaintiff was informed of all aspects concerning sterilisation because she attended ante-natal classes. It was also conceded by Dr Mavetera that it is highly undesirable to use acronyms on consent forms. It is not disputed that the first plaintiff had been in labour for 14 to 15 hours. It must be accepted as testified by the plaintiff that she was in severe pain. It was Dr Mavetera's evidence that when he explained to the plaintiff that he had to perform a caesarean section she decided that she wanted to be closed i.e. wanted to be sterilised. The consent obtained from the plaintiff for the sterilisation procedure was obtained under circumstances (testified to by Dr Kimberg) under which no consent should be obtained from a patent by a surgeon. It was obtained at the height of labour, there could not have been any proper counselling in the absence of any record of what information had been provided to the plaintiff, and it certainly, in view of the circumstances, was not obtained in an unhurried fashion. Dr Krönke unequivocally accepted that consent should not be obtained during labour – at least not obtained for the first time. Dr Mavetera was of the view that it was reasonable to do a caesarean section on the plaintiff aged 26 years at that stage due to the fact that it was her second live birth. In view of the undisputed testimony of Dr Kimberg that a woman aged 30 years or less at the time of the operation is more likely to be dissatisfied with a sterilisation and would seek a reversal, the decision taken by

Dr Mavetera appears to me not to be so reasonable as it was made out by Dr Mavetera under those circumstances and sounded more like an afterthought, an *ex post facto* rationalisation. Dr Mavetera correctly conceded, in my view, during cross-examination that he should rather have advised the first plaintiff to return after six weeks for the sterilisation procedure.

[69] It is apparent from the authorities referred to *supra* that knowledge of the nature and extent of the harm and risk and an appreciation thereof do not necessary equal consent. Even though the evidence of the first plaintiff had been criticised by Ms Schimming-Chase who appeared on behalf of the defendant such criticism cannot detract from the circumstances under which the first plaintiff's consent had been obtained, namely in circumstances in which the first plaintiff could not have given informed consent in the sense referred to by the authorities *(supra).*

[70] Dr Kimberg testified that one of the factors which should be taken into account in reaching informed consent is for a patient to be aware of and be able to evaluate alternative options available after having been duly informed of such alternatives. In this regard it would appear to me that where sterilisation, as one of the methods of contraception, is considered the patient should be informed of advantages and disadvantages of alternative contraception methods. This in my view would enable such a patient to truly make an informed decision. In respect of the second plaintiff Dr Gurirab who testified that he would have explained what a caesarean section was to the second plaintiff including the advantages and disadvantages, conceded that such explanation was not reflected in the ante-natal care record. He also conceded during cross-examination that there was no inscription on the passport that alternatives to sterilisation had been explained to the second plaintiff. It should in my view be accepted (as testified by Dr Gurirab) that he did not raise the issue of sterilisation with the second plaintiff. In view of an inscription on the medical record of the plaintiff it is likely that the

doctor who performed the caesarean on the plaintiff, raised the issue of sterilisation with the plaintiff. Nurse Ndjala who testified that she would have explained to the plaintiff that plaintiff was to be sterilised significantly testified that the consent was given by the plaintiff while she was in labour. She also assumed that the plaintiff wanted to be sterilised in view of an inscription on the ante-natal care record and that it was not necessary to counsel her again. Nurse Ndjala also significantly testified that she would have given the explanation to the plaintiff during intervals when there were no contractions. She also admitted that the instruction which was given to her on 9 December 2007 by the doctor, according to the notes recorded on the maternity record, was to prepare the plaintiff for a caesarean section *only,* there being no reference to a sterilisation. This was another example of consent being obtained from the plaintiff by a health official professional under circumstances where the patient was in the height of labour. Dr de Klerk conceded that the inscription on the ante-natal record made by herself would not necessarily be read as an accepted option by the plaintiff. Dr de Klerk also accepted that the fact that the plaintiff may have opted for sterilisation as a family planning method cannot be relied on for purposes of claiming that plaintiff had given her informed consent to the sterilisation procedure. Dr de Klerk when asked if she had been the surgeon performing the sterilisation procedure would she have been satisfied if a patient signed a consent form at their discussion, stated that she would not have been satisfied

[71] Ms Schimming-Chase submitted that the second plaintiff's version was unreliable since she had contradicted herself and that the testimony was not in line with various inscriptions on her health passport and differ markedly from the testimonies of defence witnesses. Even if it is accepted that she was not an entirely satisfactory witness and her version should be disregarded, the question remains, namely, did the defendant on the version of the defence witnesses, having regard to the concessions made, discharged its onus to prove informed consent was given by the plaintiff on a preponderance of probabilities ? I think not.

[72] In respect of the third plaintiff it appears from the notes made on 13 October 2005 that the third plaintiff was in a prolonged first stage of labour and the plan decided by the doctors was for her to undergo a caesarean and a sterilisation. Dr Krönke testified that in her capacity as a consultant she would not have obtained any consent from the third plaintiff.

[73] Dr Sichimwa testified that he must have explained the sterilisation procedure to the plaintiff. He further testified that he had assumed from the notes made by Dr Krönke on 30 March 2005 that the sterilisation procedure was canvassed with and explained to the plaintiff on that day. This was an incorrect assumption based on the evidence of Dr Krönke. Dr Sichimwa conceded that he had no independent recollection of what was specifically said to the plaintiff and had to rely on his notes. There is no reason apparent from the medical records why a sterilisation procedure was performed. His reason for failing to make notes is a poor excuse.

[74] Nurse Tjimbundu testified that the *doctors* would decide the required treatment in respect of a specific patient. The impression which is gained from the evidence of defence witnesses who had testified regarding what information is conveyed during group sessions in respect of family planning and regarding the different contraception methods appear to sufficient information and that individual counselling is not only unnecessary but also impractical. Nurse Tjimbundu's evidence contradicted this impression where she testified that family planning at group sessions would not constitute counselling in any sense and that individual counselling is still required.

[75] The importance of proper and complete record keeping is best demonstrated if one has regard to what happened in respect of the third plaintiff. As conceded by Dr Krönke during cross-examination there is no indication in all the hospital records that the plaintiff had given consent at any time before her surgery.

[76] Regarding the consent forms signed by the plaintiff this was another demonstration where a patient was required to sign consent forms during the height of labour. It was accepted, for the reasons mentioned by the witnesses, that such a practice is highly undesirable.

[77] I am not convinced even should I have regard only to the evidence of the witnesses called on behalf of the defence that the defence has discharged its onus on a preponderance of probabilities that the third plaintiff has provided informed consent in respect of the sterilisation procedure done on her.

[78] It must be stated that one has an appreciation of and sympathy for the abnormal circumstances, as testified by the witnesses, under which physicians and other health professionals must work at State Hospitals.

[79] Regarding the issue of group counselling when family planning is discussed Dr Kimberg testified that individual counselling is required. In view of the testimony of Dr Krönke and other health professionals individual counselling due to the large number of patients is simply impractical. I agree that even though individual counselling may be an ideal situation in which to do proper and skilled counselling one should not close one's eyes (figuratively speaking) to the realities encountered at State Hospitals. I can see no reason why group counselling cannot be adequate and sufficient, provided that skilled counsellors are engaged and information is conveyed in languages which are understood by the patients requiring such counselling.

[80] In respect of the first claim I am of the view that the defendant has failed to discharge its onus to prove that all three the plaintiffs had given informed consent in respect of their respective sterilisation procedures and that the plaintiff's should succeed in respect of this claim.

[81] In view of this finding I deem it unnecessary to deal with the alternative claim.

[82] In respect of the second claim the plaintiffs allege that the sterilisation procedures were performed on them because of their HIV status and that this resulted in an unlawful practice of impermissible discrimination against them. Since the plaintiffs claim that they were sterilised because they were HIV positive I am of the view that the *onus* is on them to prove this to be the case on a preponderance of probabilities.

[83] I am of the view that there is no credible and convincing evidence that the sterilisation procedures had been performed on the plaintiffs due to the fact that they are HIV positive. The second claim stands accordingly to be dismissed.

[84] In the result the following orders are made:

1. The first claim in respect of each of the plaintiffs succeeds.

2. The second claim in respect of each plaintiff is dismissed.

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HOFF J

ON BEHALF OF THE 1st – 3rd PLAINTIFFS: **ADV. D SMUTS SC**

ASSISTED BY ADV. N BASSINGTHWAIHTE

Instructed by: **LEGAL ASSISTANCE CENTRE**

ON BEHALF OF THE DEFENDANT: **ADV. E SCHIMMING-CHASE**

Instructed by: **GOVERNMENT ATTORNEY**