Consent – the basics

Advice correct as of July 2016

Respect for patients’ autonomy is expressed in consent law; to impose care or treatment on people without respecting their wishes and right to self-determination is not only unethical, but illegal.

Key principles

Mostly, the practice of obtaining a patient’s valid consent for a procedure or treatment is a straightforward one; a case of following logical, sensible guidelines. However, there are circumstances under which dilemmas can occasionally emerge for clinicians – conflicting principles, both ethical and legal, must be resolved if valid consent is to be taken.

For valid consent to be taken:

1. The patient must be competent.
   Assessment of a person’s capacity should be based on his/her ability to understand, retain and weigh in the balance the information relevant to a particular decision. (See section on Capacity.)

2. The patient must have sufficient information to make a choice.
   Without adequate information, patients are unable to make decisions about their treatment. The information provided should, for example, include: an explanation of the investigation, diagnosis or treatment; an explanation of the probabilities of success, or the risk of failure; or harm associated with options for treatment, and details of the costs of various treatment options. The patient should be given time to ask questions. (See Information overleaf.)

3. The patient must be able to give his/her consent freely.
   Pressuring patients into consenting to treatment invalidates the consent. Be aware, too, that patients’ friends and relatives may also try to exert their influence and that this can be subtle but nevertheless powerful. (See Voluntariness overleaf.)

Any failure to respect these rights of the patient will be met with either a complaint to the HPCSA, civil or criminal proceedings for assault, or a negligence claim, or one or more of the above.

Capacity

There are two components of legally recognised capacity – age and decisional capacity.

Age
   The age of full legal capacity in South Africa is 18 – therefore, in terms of consent to clinical treatment and procedures, it can be assumed that people aged 18 and over have the capacity to make decisions on their own behalf. This is unless there is a strong reason to believe that there is a mental impairment or some other impediment that compromises their ability to make such decisions. A child does not have the capacity to agree to pay for the cost of treatment; agreement for the payment of costs must be sought from an adult.

Decisional capacity
   Decisional capacity (or mental capacity) refers to the capacity to make decisions based on information received about relevant risks, benefits and consequences of the proposed intervention.

   A person’s capacity to consent to treatment is determined with two key principles:

   - Adults are presumed to be competent to make decisions. To be in a position to intervene without their consent, you must be satisfied that they lack the capacity to make decisions.
   - Minors are generally presumed to lack decisional capacity. To intervene with their consent, you must be satisfied that they have the capacity – and the maturity – to make a particular decision.

   In terms of s129(2) of the Children’s Act 38 (2005), a child may consent to his/her own medical treatment or the medical treatment of his/her child if he/she is over the age of 12 years and is of sufficient maturity to understand the risks of the treatment and the benefits associated with the treatment.
In terms of s129(3) of the Children’s Act 38 (2005), a child who is over 12 years of age may consent to surgical operation on him/herself or his/her child provided that he/she is of sufficient maturity to understand the risks and benefits of such surgical operations and has been assisted by a parent or guardian.

However, it is worth noting that decisional capacity is not always so straightforward. A patient might be perfectly capable of grasping the implications of minor surgery, but also have difficulty comprehending the risks and benefits of a procedure that is much more complex.

The time at which consent is taken may also be crucial – a patient’s decisional capacity may fluctuate over time, even during the course of one day.

Assessing decisional capacity
A person’s decisional capacity should not be judged simply on the basis of age, appearance, condition or any aspect of his/her behaviour. If a patient’s decisional capacity is in doubt, an assessment should be carried out. In general, this means conveying information to the patient with the use of plain and uncomplicated language, discussing it to gauge his/her understanding and then asking questions about the salient points to see if the patient has grasped them. The focus should be on the reasoning the patient employs to arrive at a decision, rather than on the choice the patient makes – ie, not what the patient decides, but how he or she decides.

Patients with cognitive impairment should be supported and encouraged as much as possible to exercise their decisional capacity. This means delivering information in a form that they can understand and using visual and other aids to assist them if necessary. A speech and language therapist, a translator, or other professionals with special skills or knowledge might be needed to help with communication. Even if a patient lacks decisional capacity, they should still be involved, as far as possible, in decisions that affect their lives. Patients who lack the decisional capacity to consent to treatment may still be able to assent (ie, indicate their willingness to go along with the proposed treatment).

The process of assessing a patient’s decisional capacity should be carefully documented, including all the evidence gathered to inform the judgment about the patient’s decision-making abilities – eg, past decisions made by the patient, the views of family and carers, and the results of formal functional tests.

Information
It is an offence to provide a health service to a user without their informed consent, under the National Health Act 2003 (there are some exceptions to this, such as in cases of emergency or when there is a risk posed to public health). In addition, the National Patients Health Charter (2008) states: “Everyone has a right to be given full and accurate information about the nature of one’s illnesses, diagnostic procedures, the proposed treatment and the costs involved for one to make a decision that affects any one of these elements.”

The HPCSA has issued guidance regarding issues to bear in mind when deciding what information the patient needs to know. It covers discovering more about patients’ beliefs, culture, occupation and any other factors that may have an influence on the type of information they need to know. Each patient will take a different view of the risks and benefits, and may have different priorities within their own lives. For example, a patient who makes a living repairing watches is likely to place a great emphasis on the consequences of brachial nerve damage. Any information should be presented in a form and language that the patient can understand, with their level of literacy also to be considered.

A patient must be informed of the costs of the healthcare services before the service is provided. A practitioner cannot unilaterally determine what price they want to pay for treatment. Patients can be given a written cost estimate wherein a breakdown of the costs of the proposed service is set out, or the patient can be referred to a display or pamphlet or a website setting out costs, or the costs can be given to the patient verbally.

Voluntariness
Following the granting of consent, a patient may then subsequently claim that their “consent” was not given freely – and was instead coerced out of them through overt or subtle pressures. Overt coercion is not particularly common but it is important to remember that, as the treating clinician, you may inadvertently apply pressure to consent – by assuming the patient will not object to treatment. A patient will usually find it difficult to challenge any such assumption from a doctor and, indeed, may simply find it difficult to even say “no”. Any patients who are detained by the police, immigration authorities or prison service are particularly vulnerable to this, and must be made aware that they can refuse treatment if they so wish.

Involuntary mental health patients
Involuntary and assisted mental health patients do not lose their right to treatment for illnesses other than mental illnesses, according to the Mental Health Care Act 2002. However, exceptions can be made if a mental healthcare practitioner considers the patient to be incapable of giving consent, due to mental illness or intellectual disability. In such cases, a court-appointed curator or family member may consent on the patient’s behalf.

Treatment for mental illnesses without the patient’s consent may only be given under the terms of the Mental Health Care Act 2002. However, under no circumstances can psychosurgery be performed on a mental health patient without the patient’s consent.
Recording consent

Who takes it?
The person who takes consent should, ideally, be the one who is giving the patient the information they need about the proposed treatment. If this is not practicable, the duty can be delegated to someone else – not necessarily a doctor – as long as they are suitably qualified and trained. They must also have sufficient knowledge of the proposed treatment, understand the inherent risks and be able to comply with HPCSA guidance on consent.

Doctors who delegate consent-taking duties do, however, remain responsible for ensuring that the patient has been given sufficient time and information to make an informed decision, and that the consent is valid.

The taking of financial consent can be delegated as long as that person has been properly trained. The practitioner will remain personally responsible for the proper taking of informed financial consent from the patient. Failure to take financial consent may result in a complaint to the HPCSA and may make payment of the account unenforceable.

When should it be taken?
There is no particular time limit on consent taken in advance, but for elective procedures it is often taken in the outpatient department weeks or even months prior to admission for surgery. Factors such as patients’ growing doubts, or patients’ conditions changing, may have an influence on matters, and it is good practice to confirm the consent just before the procedure. It also offers the patient an opportunity to ask any new questions. Any such confirmation of consent should be documented in either the patient’s medical record or as a supplementary note on the original consent form.

Implied and express consent
Express consent will normally be given by the patient for invasive procedures, and this will be recorded in either a signed consent form or in a statement from the patient. Written consent should always be taken where the treatment or procedure is complex and involves significant risks. For more on when to take written consent, refer to HPCSA guidance.

However, patient compliance can imply consent – for example, if they roll up their sleeve for a blood sample. Patients should still always be told about the nature and purpose of any investigation, examination or procedure. These discussions should always be documented in the medical record.

Withdrawing consent
A patient with decisional capacity may also withdraw consent for continuing treatment. If this occurs, you should only stop the procedure when it is safe to do so, and then explain the consequences of stopping the treatment – without implying coercion.

Further information
- Premier of the Province of KwaZulu-Natal v Sonny (047/10) [2011] ZASCA 6, 4 March 2011

Parts of this factsheet are based on the booklet Consent to Medical Treatment in South Africa: an MPS Guide authored by Sandy Anthony.