Court name
Supreme Court

Case name
Government of the Republic of Namibia v LM and Others

Media neutral citation
[2014] NASC 19

Flynote

HR

Health

Family

Sexual and reproductive health

Dignity and honour and reputation

Liberty

Judge Shivute CJ

IN

THE SUPREME COURT OF NAMIBIA

CASE NO: SA 49/2012

DATE:
03 NOVEMBER 2014

REPORTABLE

In

the matter between:

GOVERNMENT

OF THE REPUBLIC OF NAMIBIA.....Appellant

And

LM.....First Respondent

MI.....Second Respondent

NH.....Third Respondent

Coram:

SHIVUTE CJ, MARITZ JA and MAINGA JA

Heard:

17 March 2014

Delivered:

3 November 2014

APPEAL
JUDGMENT

SHIVUTE

CJ (MARITZ JA and MAINGA JA concurring):

Introduction

[1]
The respondents are all female Namibians
who were sterilised by way of a surgical procedure or operation known as bilateral tubal ligation (BTL) at two separate State hospitals on different occasions in 2005 and 2007. The first and third respondents were sterilised in 2005 at Oshakati State Hospital and Katutura State Hospital respectively. The second respondent was sterilised in 2007, also at Oshakati State Hospital. In the case of all respondents, the sterilisation procedure was carried out at the same time as the

caesarean section. As a consequence of the operations, each of the respondents separately instituted an action in the High Court against the Government (which in this court is the appellant) for damages arising from what she alleges in the principal claim to be an unlawful sterilisation performed on her without her consent by medical personnel in the employ of the State. In the alternative, it was alleged that the medical personnel breached a duty of care they owed towards the respondents. Each respondent claimed violations and infringements of her common law rights to personality; alternatively a violation of the right to human dignity protected under Art 8, the right to liberty protected under Art 7, and the right to found a family guaranteed under Art 14 of the Namibian Constitution. In a second claim, the respondents alleged that the sterilisation procedures were performed as part of a wrongful and unlawful practice of discrimination against them on account of their Human Immunodeficiency Virus (HIV) positive status. The claims instituted by each of the respondents were identical and, for that reason, were consolidated and heard together.

[2]
In respect of the principal claims, the
High Court ruled that the appellant had failed to discharge the onus placed on it to prove that the respondents had given their informed consent to the sterilisation procedures. In light of this finding, the High Court did not find it necessary to deal with the alternative claims related to the alleged breaches of duty of care on the part of the medical personnel. The second claim, which related to alleged discrimination on the basis of the respondents' HIV positive status, failed as that court could not find any credible evidence to support such a claim. I must pause to observe at the outset that the High Court was entirely correct in dismissing the respondents' second claim, as there was absolutely no evidence on the record to support the respondents' belief, as articulated in their evidence, that there was in place a policy or arrangement to sterilise women of child-bearing age who were HIV positive. I make this observation at the outset, because the tenor of the respondents' evidence strongly suggests that they believe that their HIV positive status was the primary reason for their sterilisation. Such a notion is entirely unsupported by the evidence.

General
remarks

[3]
Before
considering the relevant factual background of this case, it is necessary to make the following general remarks. The Namibian Constitution affords every individual in Namibia the right to dignity,[1]
to
physical integrity,[2]
and
to found a family.[3]
The
right to found a family includes the right of women of full age to bear children and of men and women to choose and plan the size of their families. In the case of an unmarried woman, it is primarily her choice, in the exercise of her right to self-determination, whether or not to bear children. Against this background, the decision of whether or not to be sterilised is of great personal importance to women. It is a decision that 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 sterilisation freely and voluntarily.

[4]
As I understand the arguments of the
parties, it is agreed that a sterilisation procedure may not be conducted without the informed consent of the person subjected to the operation. What the parties do not agree on is whether or not such consent was given by the respondents in this case. The appellant says that informed consent was given and the respondents contend to the contrary. Whether or not the respondents gave their informed consent to the sterilisation procedures is largely a factual question. For that reason, it requires a consideration of the circumstances in which the respondents allegedly gave their consent. Such consideration requires setting out a summary of the evidence led by each of the parties. It is to this summary that I turn next, beginning with the evidence led on behalf of the respondents.

Evidence

for the respondents

[5] All the
respondents testified during the course of the proceedings. In
addition, an expert witness, Dr Kimberg, was called on their behalf.
The evidence presented on behalf of the respondents may be summarised
as follows.

First
respondent

[6] The first
respondent was tested for HIV at Grootfontein upon falling pregnant
and tested positive. At the time, she was told that pregnant women
were tested for HIV in order to put women who tested positive on
antiretroviral (ARV) treatment. This, she was told, might ensure that
her child would be born healthy. The first respondent also testified
that sterilisation was not discussed with her during the subsequent
antenatal care visits she made at Ongwediva Clinic.

[7]
On 13 June 2005, the first respondent experienced severe pains after
having already been admitted to the Oshakati State Hospital. At
around 12h00, a doctor examined her. A nursing student then spoke
with her in the first respondent's mother tongue, Oshiwambo language,
apparently translating for the attending doctor who spoke in English.
The student nurse told the first respondent that she was in severe
pain, too tired to give birth naturally, and that she would have to
undergo a caesarean section. The first respondent testified that at
the time she simply wanted help, as she was in severe pain and did
not object to having the caesarean operation. According to the first
respondent, a nurse then came into the room and told her that her
uterus would be removed because all women who were HIV positive must
have their uteri removed and that the doctor had already explained
this to her. The nurse then brought documents to the first respondent
and told her to sign. The first respondent reported that the nurse
spoke to her in a ‘forceful’ manner. She did not
understand the content of the documents, and they were not explained
to her. Nor was anything else explained to her at this time. She was
not accompanied by anyone else, and was taken to theatre immediately
after she had signed the documents. The first respondent was 26 years
old at the time and indicated in her evidence to the court that she
wanted to have more children.

[8]
She returned to Ongwediva Clinic for postnatal care after the caesarean procedure and to obtain family planning in the form of contraceptives so that she would be able to prevent another pregnancy until her last born was older. The nurse at the clinic then told her that she could not receive contraceptives because she was ‘closed’. Only upon her visit to Dr Kimberg, in preparation for the hearing, was it explained to her what sterilisation meant.

[9]
During cross-examination, it was put to the first respondent that she was scheduled to undergo a caesarean section as an emergency procedure after being diagnosed with Cephalopelvic Disproportion (CPD), which in layman's terms means that the head of the foetus is too large to pass through the mother’s pelvis without trauma. The first respondent denied that the diagnosis of CPD was ever explained to her. She stated that she signed a consent form shortly before she went into theatre and whilst experiencing severe labour pains. Both parties agree that the first respondent signed one consent form standard for all kinds of operations where it was indicated that she was giving consent ‘for a C/s due to CPD + BTL (on HAART)’ and that this form was signed during labour. According to the first respondent, she did not know what the abbreviations meant, nor were they explained to her. The first respondent contended that she had gone to the hospital to give birth, and that she had neither requested nor consented to the sterilisation procedure. She further stated that the sterilisation procedure was performed on her due to her HIV status.

[10]
The appellant contended that the sterilisation procedure was conducted on the first respondent at her own request after both the caesarean section and the sterilisation procedure were explained to her and her written consent had been obtained. It was put to her in cross-examination that she had requested the procedure in Oshiwambo language using the words 'Onda hala okupatwa', meaning 'I would like to be closed'. It was further put to her that two witnesses, Dr Mavetera and Nurse Angula would give evidence to that effect. Neither of the mentioned witnesses in fact testified that the first respondent requested the procedure in the alleged terms. The witnesses testified that they had no independent recollection of the first respondent and that the only reason they had claimed she requested sterilisation was because there was a standing procedure that sterilisation be performed only when requested by a patient.

[11]
In connection to the question of whether the nature and consequences of the sterilisation procedure had been explained to the first respondent, the appellant submitted that she had received adequate counselling during the four antenatal classes that she attended, and that during these classes she would have been informed of the various methods of contraception available as an alternative to sterilisation. The appellant also argued that during these classes the nature and consequences of sterilisation procedures would have been explained to the first respondent.

Second respondent

[12]
The second respondent was HIV positive when she was pregnant with her second child. She testified that she had received counselling from Red Cross volunteers when she tested positive, and that she went to antenatal care sessions but only ‘for them to check the progress of the pregnancy, not for counselling’. During one of her visits to the antenatal care clinic, she was informed that her foetus was in a breech position, which was confirmed by a doctor to whom she was referred. The doctor informed her that she would have to undergo a caesarean section, and that as she was HIV positive, she would be ‘closed’ and never have children again. She was advised to agree to the sterilisation procedure. The doctor, according to the second respondent, did not inform her of the advantages and disadvantages of sterilisation, nor did he ask her whether she wanted to have children again.

[13]
She continued to testify that the nurse who attended to her hurried her to sign the consent form and told her that she would not be taken to theatre unless she had signed the form. She also claimed that she was not given any time to read the forms. According to the second respondent, she did not want to be sterilised but was not informed that she could refuse the operation. The consent form that she signed stated ‘BTL due to previous caesar’. She did not understand the abbreviation 'BTL,' nor had anyone spoken to her about a previous caesarean section being the reason for the operation.

[14]
The second respondent testified that she
was shocked when six months later she found out that she was
sterilised. She anticipated that her sterilisation would cause a
conflict between herself and her parents-in-law because they expected
her to bear more children.

[15]
During cross-examination, the second
respondent testified that she did not receive any family planning
information during the antenatal care sessions. The family planning
information she received during postnatal care did not include
information on sterilisation. She did, however, state that she knew
what sterilisation meant from her Grade 11 and 12 education, and knew
what the nurse meant when she said that she would be sterilised.
However, the second respondent maintained that the nurse did not
explain this to her. Initially, the second respondent claimed to know
what reversible and irreversible sterilisation meant. She later
changed her testimony to state that she did not know what reversible
and irreversible sterilisation meant. The second respondent further
stated that she only agreed to the sterilisation procedure because
the doctor forced or threatened her to undergo the procedure. She did
not say anything about the impending sterilisation when she was in
labour because she thought that the doctor would not go through with
the procedure and she was in too much pain to inform the doctor that
she did not want to be sterilised. She also testified that the nurse
only showed her where to sign the consent form shortly before she
went into theatre, and that she did not read the document.

[16]
During re-examination, the second
respondent testified that the doctor was a person in authority and
she was under the impression that there was a policy in place that
required all HIV positive women who were pregnant to be sterilised.
She also testified that she only expected the caesarean section to be
performed to save her baby's life, and that when she signed the
consent form she focused only on the areas where she was shown to
sign.

**Third
respondent**

[17]
At the time of the sterilisation procedure,
the third respondent had given birth seven times and one of her

children had passed away. This was her eighth pregnancy. Her last child was born when she was 46 years old. She testified that during the third month of her pregnancy, she went to hospital because she was experiencing severe pains that prevented her from walking and moving normally. She testified that she requested at this time to be 'cleaned' by the doctor, as she believed that her pregnancy should be 'removed' because she thought she 'would die'. She was informed that her pregnancy could not be removed because her foetus 'was too big', meaning that she had progressed too far in her pregnancy for it to be terminated.

[18]
When the third respondent was taken to hospital to give birth, she was experiencing prolonged contractions and the nurse hurried her to sign a form. She stated that she was simply told to write her name on a form but that its contents were not discussed with her. Nor were the sterilisation or caesarean section procedures explained to her. She testified that the nurses did not communicate with her in Oshiwambo (the only language she understood) and that they spoke only in English.

[19]
The third respondent also asserted that she had received no counselling before 2005 when she discovered that she was HIV positive, although it was written on her health passport that counselling was provided at the time. She speculated that the nurses could have spoken to her in English, which would mean she did not understand what they were saying. Further, she stated that she did not receive any counselling on contraceptive methods, including sterilisation, during the antenatal sessions she attended. The participants found the nurse's responses to their queries unhelpful: when participants asked questions for the purpose of clarification, the nurse typically asked in turn why the women had become pregnant when they were HIV positive. The third respondent received no counselling during antenatal and postnatal care sessions, only from a support group in 2007.

[20]
During cross-examination, the third respondent stated that at the time of the birth she simply wanted the pain to be eased but never said that she wanted her pregnancy to be terminated. She denied that Dr Iithete, an Oshiwambo native speaker, spoke to her in Oshiwambo. In fact, she said that Dr Iithete never spoke to her and she had not seen him before. She also denied that Dr

Krönke, another witness called by the appellant, had informed her about sterilisation and advised her to have a caesarean section in the presence of an interpreter. She further denied that Dr Krönke had discussed other matters indicated on her health passport. According to the respondent, she did not make a booking for a caesarean section or sterilisation because she wanted to give birth naturally. Any consent given in connection to these procedures was given without the third respondent understanding why she was giving it.

Doctor
Matti Kimberg

[21]
As indicated above, the respondents called Dr Kimberg, a gynaecologist and obstetrician who had been practising medicine for approximately thirty years at the time of his testimony. At the time, he was also the Vice-President of the Medical and Dental Council of Namibia and was a member of the Executive Committee of the Medical Association of Namibia. He stated that he was well-acquainted with the ethical standards and literature regulating the health professions in Namibia. I accept that he is an expert in gynaecology and obstetrics.

[22]
Dr Kimberg performed a laparoscopy on each of the three respondents to establish whether BTL had been performed and, if so, whether it was reversible. He confirmed that the three respondents underwent BTL operations, explaining that BTL involves cutting or tying the fallopian tubes of a female patient. The reversibility of a BTL procedure depends on whether the ‘little fingers’ at the end of the fimbriae are damaged in the course of the procedure. If they are not damaged, it is possible to reverse sterilisation rendering the patient capable of bearing children again.

[23]
According to Dr Kimberg, the first and second respondents had a very poor prognosis for reversal because their fimbriae were scarred: the procedures had not been carried out with reversal in mind. The third respondent had a good prognosis for reversal. However, her chances of another pregnancy were very poor due to her advanced childbearing age.

[24]
The doctor also testified that during
labour a woman might experience pain of such a level and intensity that she loses a sense of reality; she may stop thinking rationally. A woman may be aware only of the pain, and may ‘grasp at straws’ to be relieved of such discomfort. Dr Kimberg opined that consent should not be obtained from women in circumstances when they are experiencing so much pain. According to him, many women in the height of labour say that they would not choose to experience the pain of childbirth again, yet many still return with a pregnancy the following year.

[25]
Dr Kimberg also emphasised that the type of
consent required from women for procedures such as sterilisation is informed consent. This means that a woman considering sterilisation must be able to understand the relevant information given to her and exercise autonomy in making her decision; must be able to assimilate, retain, and weigh the information; must be able to properly communicate her decision; must not be subjected to any undue influence by her particular situation or environment, or be coerced by medical personnel or any other person; must be aware of the long and short-term consequences of her decision; must be able to evaluate alternatives to the procedure; and must be informed that she can withhold consent. He set out the above requirements with reference to some of the literature referred to in evidence, including a textbook titled ‘*Midwifery*’,
Volume 1, by P. McCall Sellers, which he acknowledged is also applicable to Namibia.

[26]
Dr Kimberg also emphasised the importance
of keeping proper clinical notes, especially in state hospitals where patients are seen by many different doctors who rely largely on notes taken by colleagues who have seen the patients earlier. Indeed, the evidence in this appeal reveals that the respondents were seen by different doctors and nurses before the sterilisation procedures were performed on them. It is also apparent from the record that the clinical notes kept by the health professionals involved in the treatment of the respondents were entirely inadequate and incomplete, and did not comply with the required standards. To varying degrees, this fact has been acknowledged by the respondents’ witnesses.

[27]
Dr Kimberg referred to a book by John Guillebaud, '*Contraception – Your Questions Answered*', as a widely accepted authority on the topic of consent. In that book, the writer says that sterilisation must not be an afterthought but must be initiated prior to labour in a non-directive manner and without pressure. On his part, Dr Kimberg would have hesitated to obtain consent from each of the three respondents for the sterilisation procedure 'in the painful, unstable and disturbing conditions' experienced by each of the respondents at the height of labour. This was particularly the case because there were other less invasive, easily reversible and equally effective methods of contraception available that could have been utilised. He also stated that women may request a reversal of a sterilisation procedure if and when their circumstances change, which is why it is advisable to perform the procedure with possible reversal in mind.

[28]
Dr Kimberg agreed, however, that it was unlikely that a health worker would simply accept a health report on its face value without confirming it with the patient. He also conceded that even if a woman has been irreversibly sterilised, she could still, in theory, travel to South Africa for in vitro fertilisation. The process is however very expensive and accordingly not an option for many women. Furthermore, Dr Kimberg agreed that although it was advisable to wait for at least six weeks after a woman has given birth for her to properly give consent for sterilisation, consent given before this time is not invalid, even if such consent is given at the height of labour.

[29]
That concludes the summary of the evidence presented on behalf of the respondents. I turn next to setting out a summary of the evidence of those witnesses who testified on behalf of the appellant. This section is divided into three parts. Each part considers the appellant's evidence in connection to one of the respondents.

Witnesses

who testified in respect of the first respondent

Dr
Innocent Mavetera

[30]
Dr Mavetera obtained a MD degree in 1995
and specialises in obstetrics and gynaecology. He had worked at
Oshakati State Hospital but was in private practice at the time he
testified.

[31]
Dr Mavetera confirmed certain details
related to the consent form signed by the first respondent. He
confirmed that the consent form used at the relevant time at Oshakati
State Hospital was one standard form for all operations performed on
patients at the hospital. Separate consent forms for specific
operations were only introduced at that hospital later. The consent
form previously used did not distinguish between specific operations
performed on a patient, but was nevertheless considered sufficient
until it was replaced.

[32]
Dr Mavetera confirmed on the basis of the
first respondent's health passport that she was discharged on 16 June
2005 and had attended antenatal care sessions on a few occasions. The
first respondent could not give birth by normal delivery because she
suffered from CPD, which, as previously mentioned, indicates that the
foetus' head was too big to pass through the mother's
pelvis without trauma.

[33]
The doctor further testified that he would
have spoken to the patient in Oshiwambo, or would have used an
interpreter, to ensure that she properly understood what he was
explaining to her. Although he did not have an independent
recollection of the respondent, he was certain that he would have
followed the proper procedures. It was explained to the respondent
that it was necessary for her to undergo a caesarean section and why

it was necessary. The medical personnel would not have performed the sterilisation procedure unless the patient had requested it. Therefore, in Dr Mavetera's view, the first respondent must have requested the sterilisation procedure. Although her health passport indicated that she had attended antenatal care sessions, and it could therefore be assumed that she understood what sterilisation involved, Dr Mavetera said that the procedure would have been explained to the patient again and included an explanation that the procedure was permanent.

[34]
He also testified that the use of abbreviations on health passports is acceptable because health passports are intended to be used by health practitioners who communicate with each other by making recordings therein for the next health practitioner to see. In light of their heavy work load, it is valuable to health practitioners that the use of abbreviations means that they do not have to peruse the entire health record of each patient, thus saving time. He testified that everything noted on the health passport would be explained to a patient even if the situation was not fully recorded due to the heavy workload of health practitioners. Dr Mavetera confirmed that Nurse Angula was the nurse who had translated what the doctor had explained to the respondent in her home language.

[35]
During cross-examination, Dr Mavetera conceded that doctors had an ethical duty to keep proper notes; that he was aware of the socio-cultural implications if a woman was unable to bear any children; that there were different thresholds of pain; and that a patient did not have to be sterilised in order for a caesarean section to be performed on her. When questioned by counsel for the respondents on the abbreviations used on consent forms, Dr Mavetera responded that patients may not know what the abbreviations used on consent forms stood for but that those abbreviations are explained to patients. He conceded that consent forms are used not only by hospital staff but by patients as well, and that without explanation most patients would not be able to understand what was meant by the abbreviations. He also conceded that it was preferable to send the patient home with the consent forms so that he or she may properly consider what they are consenting to before they sign the form. The new consent forms that have since been adopted by the hospital are far easier to understand, because the type of procedure consented to by the patient is highlighted in bold on the top of the form.

[36]
Dr Mavetera maintained that the
alternatives to the procedure would have been explained to the first respondent - although she may well have been very tired - because no operation would be performed on a patient without her informed consent. In light of their already heavy workload, Dr Mavetera said it was unlikely that health professionals would add to their tasks by performing additional procedures not requested by patients. He conceded that there was no indication in the first respondent's records that she had requested the sterilisation procedure to be performed, but Dr Mavetera was adamant that the patient must have done so. In fact, he stated, it is a standing order at the Oshakati State Hospital that patients are not to be sterilised if they do not request the procedure. The procedure may, however, still be proposed to a patient on medical grounds. He added that although the first respondent was in labour when she consented to the sterilisation procedure, she must have requested it. In those circumstances, the attending doctor must consider the wishes of the patient and weigh the alternatives. According to Dr Mavetera, the first respondent was asked for a third time in theatre whether she understood the nature of the procedure and whether she consented to it. This, he explained, was done because no nurse in theatre would allow an operation to take place unless the nurse was satisfied that the patient gave her informed consent.

[37]
Dr Mavetera also said that women are
generally sterilised six weeks after they give birth, or the day after they give birth. The first respondent came to the hospital to have a natural delivery and she was 26 years of age at that time. At this age, it was undesirable for her to be sterilised. He agreed with Dr Kimberg’s testimony that the chances for the reversal of the first respondent's sterilisation was very poor; that the procedure was not done with possible reversal in mind; that in the circumstances of this respondent the procedure should have been done with possible reversal in mind; and that although it could be mentioned to the respondent that she could opt for in vitro fertilisation, the procedure was very expensive. Dr Mavetera also accepted that it was standard practice that a doctor must not withhold any information from the patient that it is in her best interest to receive.

Nurse
Victoria Uuso Angula

[38]

Nurse Angula was a registered nurse for 18 years and is also a qualified midwife. She had worked at the Oshakati State Hospital for 16 years. She was the nurse who attended to the first respondent and had made certain notes in the hospital records of the patient. Nurse Angula testified that the first respondent's membrane broke at about 08h30 and that she saw the patient at 13h00 (she also noted that a patient who is HIV positive should not wait for more than four hours after the membrane has broken to give birth). Nurse Angula then called a doctor, who diagnosed the respondent with CPD and indicated that she would have to undergo a caesarean section. The doctor explained the procedure and its purpose to the first respondent. The consequences of the sterilisation procedure were also explained to the patient, including that she would be unable to give birth to any more children as a result of the procedure. The doctor then left, and Nurse Angula completed the consent form with the respondent, who signed it. Although this discussion was not recorded on the hospital records, Nurse Angula was adamant that it did take place. After the consent form had been signed, Nurse Angula prepared the respondent for surgery.

[39]

Nurse Angula also testified that she had previously provided antenatal care group counselling to pregnant women. She said that the sessions were typically conducted in the language understood by the women attending. Hygiene, diet, and various family planning methods were among the topics discussed during the sessions. The subject of sterilisation was also addressed during these sessions, and participants were informed that sterilisation was a permanent procedure.

[40]

During cross-examination, Nurse Angula conceded that she did not have an independent recollection of the first respondent and had relied only on the medical notes she had made for recollection. She said that when she had been informed about the case instituted against the Ministry of Health, she had perused the hospital's records, rules and procedures. She confirmed that if she did not follow these rules, she would be 'in trouble' with her employer. When perusing these records, Nurse Angula was able to establish that she had been the only nurse in the ward on the particular day in question. She had not recorded the procedures followed with regard to the first respondent, nor could she remember who the respondent was. Therefore, she conceded, it could not be said with certainty that the standing rules and procedures had been followed during the treatment of the respondent. However, she added, there was no proof that she did not apply the relevant rules and procedures. Nurse Angula also said that she did not go through the rules and procedures to reconstruct what had happened on the day in question.

[41]
Nurse Angula testified that the consent of
a patient was generally obtained in the presence of a doctor, a
student nurse and a witness. According to Nurse Angula, the nurse who
interprets to a patient is not required to make notes to indicate
that she has translated everything to the patient. Nurse Angula also
said that the time stipulated on the back of the respondent's
consent form was not necessarily accurate, as she tended to simply
note the time after a patient had signed the form. Nurse Angula did
not keep track of everything that was done during each precise
minute, but rather recorded everything she had done at once.

[42]
Nurse Angula accepted that the principles
outlined in the textbook *Midwifery*
applied to Namibian hospitals, including the principle that
'unhindered and skilled' counselling is required before a
female patient undergoes a sterilisation procedure. Nurse Angula
assumed that the first respondent had been properly counselled at the
antenatal care sessions she attended, and generally she did not
'restart with the counselling if (sic) it was already done in
antenatal care sessions'.

[43]
It was put to Nurse Angula by counsel for
the respondents that the ability of a patient to make rational
decisions was affected when she was in labour. Nurse Angula responded
by saying that labour pains 'come and go'. She also
distinguished between two types of labour pains, which she described
as 'real labour and fast labour'.

[44]
According to Nurse Angula, although she may
not recall this particular respondent, she went through this process
on a daily basis in the same manner and would have done so in the
same way with the respondent as well. She would have explained the
procedures to the respondent and obtained her consent in between her
contractions. In response to Dr Kimberg's testimony that it was
preferable not to obtain consent during labour, she responded that if
a patient requested sterilisation the procedure could not be refused.
According to the nurse, the alternatives to sterilisation were not
discussed with the respondent because this would have been properly
canvassed with her during the antenatal care sessions. The consent
form clearly showed that two operations would be performed and

therefore it could not be said, as the respondent testified, that she was under the impression that she was taken to theatre to 'have her baby removed'. Furthermore, the respondent had no reason to be afraid to ask any questions, and Nurse Angula was not aware of the existence of any kind of authority associated with the position of health professionals that may have prevented the first respondent from asking questions.

[45]
Counsel also put to Nurse Angula that it was impossible to peruse the records, call the doctor, wait for him to arrive and peruse Nurse Angula's notes, brief the doctor, complete the consent form (whilst translating everything the doctor said to the respondent) and then prepare the patient for theatre within 15 minutes. The witness responded that a student nurse assisted her and this process did not take 'that long'.

[46]
Nurse Angula also stated that the record was incomplete because she did not have sufficient time to complete it. This was because she had focused her attention on saving the respondent's baby's life in an emergency situation. In those circumstances, addressing the emergency was more important than fully completing the medical record. She also maintained that she explained the permanent nature of sterilisation to the respondent. Nurse Angula agreed that the sterilisation procedure did not need to be performed on an emergency basis, but nevertheless maintained that the first respondent had requested the BTL and there was no reason to discharge the patient only for her to return to the hospital at a later stage for that procedure when it could be performed at the same time as the caesarean section. She added that she was not aware that it was undesirable for a woman in her twenties to undergo a sterilisation operation. There was also no standing order, according to the witness, that patients who were HIV positive must undergo sterilisation, and she would not recommend such a procedure for that reason. Nurse Angula clarified that the term 'standing order' refers to those rules made by the Ministry of Health and the Head of the Division regarding the treatment of patients, covering issues such as how medication should be administered to patients.

Appellant's

witnesses in respect of the second respondent

Doctor
Celeste de Klerk

[47]
At the time of her testimony, Dr de Klerk
was practising as a general practitioner in private practice in Windhoek. She obtained her qualifications from the University of Cape Town, South Africa. In 2007, she was employed at the Katutura State Hospital and was a medical officer at the ARV Clinic, where HIV patients were treated, from 2004 to 2009.

[48]
Dr de Klerk gave evidence about the
Prevention of Mother to Child Transmission (PMTCT) program, which procedurally involves the following: the patient is booked in for an appointment and then clinically tested to establish whether she is eligible to start Highly Active Antiretroviral Therapy (HAART); the patient is counselled on the PMTCT process and issues related to disclosure of information; the patient is informed about Neverapine (a common antiretroviral drug); and the patient meets with a community counsellor (who works for the PMTCT clinic) to discuss feeding options and family planning. These discussions are conducted in layman's terms, but abbreviations may be used on the health passports. In relation to sterilisation procedures, the term 'closed' is used to illustrate to the patient that the procedure is irreversible and that she will not be able to have any more children. The patient is then given time to consider her options and make a decision on whether or not she wishes to be sterilised. A patient may subsequently change her mind after this time. The decision she takes is indicated on the front page of her health passport so that nurses at the antenatal care clinic are aware of her decision. The doctor indicated that she wrote 'BTL' on the second respondent's health passport because that is the procedure the respondent had opted for when she consulted the doctor.

[49]
During cross-examination, Dr de Klerk
testified that health passports were used by state doctors to communicate with each other. She confirmed that she wrote 'BTL' on the respondent's health passport because that was the family planning method the second respondent opted for after she was counselled. Dr de Klerk explained that the respondent had not agreed to the procedure, but instead 'opted' for it: the patient agrees only when she signs a consent form prior to the procedure. In essence, Dr de Klerk reasoned, the respondent accepted 'BTL' as a method of family planning for the future after delivery. According to Dr de Klerk, it was the duty of the doctors who would treat the

respondent in the future to confirm whether the patient still wanted to be sterilised before carrying out the procedure. These doctors would be able to note from the record that the patient had been seen for a PMTCT appointment (but not an obstetrical appointment). Dr de Klerk also added that the risks associated with the sterilisation procedure and the potential for reversal would not have been discussed with the respondent, although the patient would have been informed that having the procedure would mean that she would be unable to conceive children in the future. Dr de Klerk conceded that in circumstances where the inscription 'family planning: BTL' had been written on the health passport, the next health practitioner who assisted the respondent might conclude that the sterilisation procedure had been discussed with the respondent. Dr de Klerk also testified, however, that if she had any doubts about the second respondent's willingness to undergo the procedure, she would have made a note on the respondent's health passport to that effect.

Nurse
Even Maria Ndjalo

[50]
Nurse Ndjalo began working as a nurse in 1977. By 1986, she had upgraded her qualifications and become a midwife. At the time of her testimony, Nurse Ndjalo had been employed by the Ministry of Health and Social Services at Katutura State Hospital since 1996.

[51]
Nurse Ndjalo referred to the second respondent's consent form and testified that she had explained the contents of the form to the respondent and translated the doctor's communications to the patient in the respondent's home language. This form indicated which procedures would be performed on the respondent. Nurse Ndjalo speculated that after she had explained the contents of the form, she would have asked the respondent if she understood what had been said to her, and whether she agreed with it. If the patient agreed, and only if the patient agreed, would the patient then sign the consent form. Nurse Ndjalo added that she explained to the respondent that if she chose to be sterilised, this procedure would be permanent and she would no longer be able to have children. She confirmed that the respondent must have understood the explanation before signing the form, which would have taken place in between contractions. Although she did not make any notes to confirm this, Nurse Ndjalo was certain that she had followed these procedures.

[52]
During cross-examination, Nurse Ndjalo admitted that she saw the abbreviation ‘BTL’ on the patient’s health passport and assumed that the respondent wanted to be sterilised. She said that she would have then asked the respondent whether she still wanted to be sterilised and that she would have assumed that the respondent had already been counselled, knowing that a patient starts counselling at the antenatal care sessions. Nurse Ndjalo stated that the respondent was not forced to undergo the sterilisation operation; she must have elected to have it. She added that it was the doctor’s duty to explain the procedures to the patient and to ensure that the patient understood the explanation. She confirmed that there were no specific instructions as to how to prepare a patient for a BTL, only for a caesarean section. She also acknowledged that the textbook *Midwifery,* referred to above, provides that a patient must be properly counselled before sterilisation, and that she must be able to understand the information given to her after which she may give her consent. She also testified, however, that the book was published after she became a midwife.

[53]
Nurse Ndjalo stated that she could not recall much about the respondent save for what was written on her health records. Upon being questioned on whether she informed the respondent that her spouse could be present when she signed the consent form, Nurse Ndjalo stated that she could not recall whether she did. She contended, however, that it was ultimately the respondent’s right to decide whether she wanted her partner to accompany her to the hospital.

[54]
Nurse Ndjalo confirmed that hospital personnel work under extreme pressure and with many patients. She claimed nevertheless that she did not rush when performing her duties. She testified further that she had never heard of a patient being sterilised due to her HIV status. The witness also added that she would not speak to a patient while she was experiencing labour pains, and that she knew when contractions were severe and when they were not. Nurse Ndjalo added that the respondent’s handwriting on the consent form illustrated that she was not in pain when she signed because it was not ‘skewed’.

Doctor
Quincy Gurirab

[55]
Dr Gurirab became a medical practitioner in
2006 and started working for the Ministry of Health in 2007. He testified that he could not remember the respondent other than by reference to the health records. On the basis of the clinical notes, he was able to testify that the respondent was referred to him to confirm the breech position of her foetus. He would have explained to the respondent the advantages and disadvantages of the caesarean section operation, outlined what the procedure involves, and ensured that the patient understood this explanation. Typically, he would have also explained to the patient that a caesarean section is a surgical procedure and therefore has inherent risks, as is also the case with the administration of anaesthetic drugs. The duration of the operation and additional medication she would receive would also have been explained to the patient. Dr Gurirab added that when he saw the respondent he did not realise that she was HIV positive; if he had this would have been indicated in his notes.

[56]
During cross-examination, he conceded that
the notes in the respondent's health passport referred to 'ARV' and 'PMTCT,' which would indicate that she was HIV positive and that medication was given to her because of her status. He added that he was aware that caesarean sections were recommended for patients who were HIV positive and whose foetuses were in a breech position. Dr Gurirab said that he would have explained the caesarean section procedure to the respondent, although he did not make notes on her health records to indicate that he in fact did so. Dr Gurirab said he was aware that complete records of all explanations given to patients should be kept due to the small chance that doctors may recall patients they had previously seen and the details of their treatment.

[57]
Dr Gurirab did not include the phrase 'BTL'
in his notes because he did not discuss the procedure with the respondent. He said that he would have included the abbreviation had he mentioned such an important procedure to the patient. He testified that he was very prudent and precise when making notes. He denied that he would ever tell a patient that if she did not consent to the sterilisation procedure she would not be booked for a caesarean section.

Witnesses

for the appellant in respect of the third respondent:

Doctor
Godfrey Sichimwa

[58]
Dr Sichimwa was a medical officer in the department of obstetrics and gynaecology at Katutura State Hospital. He informed the court that the hospital had a shortage of staff and that approximately 500 babies were born per month at the hospital. He lamented the fact that the hospital was insufficiently staffed and that only a small number of health workers were available to assist with all these births, explaining the pressure under which they worked. Dr Sichimwa referred to the health records of the third respondent and confirmed that she was admitted on 12 October 2005 at about 18h50. The respondent was not booked in for a caesarean section and BTL because the health workers wanted her labour to progress naturally. Although she had been advised to make a booking for a caesarean section, she had failed to do so. Dr Sichimwa indicated that even though he did not have an independent recollection of the respondent, he must have explained to her that she had to undergo the caesarean section to expedite the delivery of her child because of her age, parity and retroviral status.

[59]
Dr Sichimwa explained that if a patient did not understand the language spoken by a doctor, one of the many nurses in the ward would be asked to interpret for the patient. The consent forms were signed in the presence of the doctor and nurse only after the patient indicated that he or she had fully understood what had been explained to her. The presence of his signature on the consent form of the respondent was proof that all the information had been given to the patient and she had agreed to the sterilisation procedure. Furthermore, the theatre nurse would generally confirm that the patient had been informed of the nature of the operation, that she understood all the information, and had consented to the procedure by giving her signature. No operation would commence unless the theatre nurse had confirmed this understanding.

[60]
In cross-examination, Dr Sichimwa confirmed
that health workers at the Katutura State Hospital worked under
immense pressure, in difficult conditions, and were constrained by
time and the availability of theatres. Doctors see many patients and
therefore rely on medical notes for recollection. He conceded that it
was therefore necessary that medical notes be complete.

[61]
Dr Sichimwa stated that he could not
confirm whether the respondent was in pain at the time she signed the
form because pain ‘was a subjective matter.’ Even though
he did not have a personal recollection of the respondent, he was
adamant that he had explained the procedure and communicated all the
relevant information to her. He concluded that this must be the case
because his signature was present on the consent form.

[62]
Dr Sichimwa conceded that the BTL procedure
could have been performed at a later stage; that it is very invasive;
and that he was aware of the cultural norm that places a high premium
on women being able to birth children. He added that there was no
reason indicated for sterilising the respondent on the consent form
or health passport, but he was certain that it was probably indicated
elsewhere on the respondent’s records. He agreed that it is the
doctor’s final responsibility to ensure that the patient gives
her informed consent. The long consent form signed by the respondent
was sufficient in that it stated that the procedures had been
explained to the respondent. He testified further that it was not a
requirement that the operating doctor should make notes before the
operation, notes are only made post operation which is why there were
specific spaces on the consent forms for that purpose. The doctor
operating on a patient may be different from the one explaining the
procedures to the patient; the latter being the one who signs the
consent form. This form only mentioned the risks, procedures and
alternatives to the procedures. Dr Sichimwa was insistent that other
information could have been given to the respondent even if it was
not recorded. He conceded, however, that additional information given
to the patient should have been noted on the medical records. He
added that the reason the notes were not complete was due to limited
space available on the stationary, but counsel promptly pointed out
to him that there was sufficient space on the forms for additional
notes under the heading ‘submissions’.

[63]
Dr Sichimwa also testified that the purpose
of ward rounds was for the health practitioners to benefit from each

other's knowledge and input. Consent from patients for operations may have been obtained during these ward rounds. Dr Sichimwa added that the reasons given to the respondent in favour of the sterilisation procedure would have included her previous request for termination of her pregnancy, her retroviral status, and her age. It was Dr Sichimwa's opinion that counselling regarding her sterilisation could effectively be provided to the respondent ten minutes before she went into theatre. This is because the topic had presumably been covered with the patient previously. Dr Sichimwa conceded that unhurried and skilled counselling was important for informed consent and that such consent should have been obtained prior to labour. He added that all women were in pain during labour but that this consideration alone did not render them incapable of giving their informed consent. He confirmed that some women would say they did not want to be pregnant again when they were in labour but would return to the hospital pregnant the following year. The witness confirmed that the third respondent did not attend the hospital to make a booking for the caesarean section or the sterilisation procedure.

[64]
In re-examination, Dr Sichimwa testified that the consent forms were signed after the third respondent had been counselled, after which she was taken into theatre. He added that if a patient did not want to be sterilised, her decision would be respected.

Nurse Erica Kamberipa

[65]
At the time of her testimony, Nurse Kamberipa had been a registered nurse since 2004. She testified that she had admitted the third respondent and made an inscription on her health passport. She said that she had spoken to the respondent in Oshiwambo. Nurse Kamberipa explained that the doctors would make decisions regarding a patient's treatment plan and then explain everything to the patient. After this, the patient would sign the consent forms for the operation if that is what was decided. She agreed that the standards of midwifery illustrated in the textbook *Midwifery* were of application to Namibia as well. She also added that in her practice she would ensure that patients signed consent forms before

they went into theatre, and that an interpreter was used to ensure that the patients understood the information before giving their informed consent.

[66]
Nurse Kamberipa had presented antenatal care sessions during 2007 and 2008. She explained that during these sessions, the women were grouped according to the languages they spoke. They were given information on hygiene, PMTCT, HIV, breastfeeding, and different forms of family planning including BTL, condoms, oral pills and injections, as well as intrauterine devices. This system of providing antenatal care lessons had been in place since 1989.

[67]
In cross-examination, Nurse Kamberipa confirmed that the standard of consent to be obtained for any operation was informed consent, and that it was important to keep proper notes. She also agreed that it was best practice for the interpreter, where one was used, to make an inscription that she had properly interpreted to the patient.

[68]
Nurse Kamberipa also said that she assumed that whoever made the inscription ‘BTL’ on the third respondent’s health passport correctly did so. When she saw the respondent, she did not speak much to her because the information was on her health passport, and she assumed that the respondent had agreed to the procedures indicated on her health passport. She added that it was logical for her to be sterilised because of the fact that she had previously undergone a caesarean section. According to the witness, it was possible that the respondent had been told about the caesarean section only because it was decided that she should undergo the procedure. She conceded that she may not have followed the correct procedure but maintained that she would have taken time to obtain the third respondent’s informed consent. She did not hurry the respondent to sign the form. She admitted that she may have said to the respondent ‘shanga’, which according to her meant 'sign' and that if she told her to do so, she did it with appropriate decorum rather than with a raised voice. Nurse Kamberipa agreed that it was her responsibility to confirm that the respondent had understood the procedure before she signed. The doctors would have explained everything to the respondent. The explanation would

have been done in ten minutes, because it did not take long when done verbally. She denied that she simply assumed that the respondent had already been counselled.

[69]
The witness added that although
abbreviations were used on the forms, they were properly explained to the patients. Nurse Kamberipa informed the court that the procedure of obtaining a patient's consent had changed since the respondents were treated: the use of abbreviations had been discontinued; doctors explained the procedures to the patients, then a nurse was required to explain again; and only doctors (as opposed to nurses) were authorised to sign the consent forms together with the patients.

[70]
Nurse Kamberipa explained that antenatal
care sessions included group counselling, after which a woman may request individual counselling. The topic of sterilisation was discussed with participants, but the focus was more on their health and the progress of their pregnancies during follow-up sessions.

[71]
In re-examination, the witness confirmed
that sterilisation was not discussed in group counselling sessions. The patient had to elect the process upon which she would be counselled accordingly and individually. The inscription ‘BTL’ would be recorded on her health passport if she elected the procedure, and she would then be referred to a doctor for further counselling (because sterilisation procedures are dealt with by doctors). Nurse Kamberipa added that antenatal care sessions involved taking blood and urine samples from the patient, determining the progress of her pregnancy, and discussing family planning for the future.

[72]
The witness also testified that
pre-anaesthesia was usually administered to a patient 30 minutes before an operation was performed. She stated, however, that this did not usually affect a patient’s mental capacity.

Doctor
Tshali Iithete

[73]
At the time he gave evidence, Dr Iithete
was a medical superintendent and Managing Director of Ongwediva Medi Park, a private hospital in northern Namibia. Before holding this position, he used to work for the Ministry of Health as a medical officer in the department of internal medicine.

[74]
Dr Iithete testified that he recalled the
third respondent as she was the first patient who was HIV positive to request the termination of her pregnancy on medical grounds. He consulted with her at length in Oshiwambo. He referred her to the PMTCT program because it was policy that terminations should only be performed due to the existence of danger to the mother or the foetus. He explained to the respondent that PMTCT involved giving the mother and baby antiretroviral therapy, which would prevent the foetus from acquiring HIV (one of the respondent's children had already died from the virus). Dr Iithete also discussed the barrier method with the respondent because her partner would be exposed to contracting the virus if it were not used. Dr Iithete also testified that records were made in health passports for the sake of continuity and for the benefit of the patient's next health practitioner.

[75]
During cross-examination, Dr Iithete stated
that the third respondent did not necessarily request the termination of her pregnancy on the basis of a medical condition. He did not recall her physical condition when she came to see him, for example, whether or not she was ambulatory. He added that there seemed to be a difference between her reasons for requesting the termination of the pregnancy when he saw her and her motivation thereafter. Dr Iithete said that the third respondent was accompanied by her partner but that if the partner had conveyed any information to him he would have confirmed it with the respondent. The witness conceded that he had recommended a hysterectomy and not sterilisation as a means to alleviate the possibility of bleeding.

[76]
He added that the respondent's HIV
status was important for the purpose of assessing her and establishing her medical history. He explained that the purpose of

health passports is to record a summary of the health issues experienced by a patient and what is actually observed and done by health practitioners attending to the patient.

Doctor
Dorothea Maria Krönke

[77]
Dr Krönke obtained her MD degree in Germany in 1985, came to Namibia in 1985, and practised at the Windhoek State Hospital until 1992. She is a specialist in obstetrics and gynaecology, and was responsible for the Katutura State Hospital and Windhoek Central Hospital. She also worked at Oshakati State Hospital for one year.

[78]
Dr Krönke stated that she did not have an independent recollection of the third respondent. She was able to testify only on the basis of the notes in the respondent's medical records. During an appointment with the third respondent, Dr Krönke had enquired whether she had considered 'the final solution'. The doctor made this enquiry because the respondent had requested a termination of her pregnancy and had seven children, including one who was HIV positive. She then informed the respondent about sterilisation as a permanent solution for someone who did not want to become pregnant.

[79]
Dr Krönke confirmed the respondent’s pregnancy by performing an ultrasound. She then sent the ultrasound to the head of the department, who had authority to make a final decision regarding whether a patient was eligible for a termination. The witness had already informed the third respondent that as she was already more than three months into her pregnancy, it was likely that her request for a termination would be declined. She asked a 'nurse or doctor' to interpret this conversation with the respondent. After she sent the ultrasound to the head of the department, the third respondent’s request for a termination was refused.

[80]
Dr Krönke also explained that because she was a specialist, 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 run by trained senior nurses. If there was anything that could not be dealt with by the nurses, the patient would be referred to a doctor. Normally the antenatal care classes involved follow-ups on the progress of the pregnancy and the patient's health. Women sat in rows set up like a classroom, and a nurse would conduct the classes. The various methods of contraception were also discussed during these sessions.

[81]
Dr Krönke explained that the phrase
‘elective’ meant ‘planned', without there being any
emergency situation. Therefore sterilisation was ordinarily referred to as an 'elective' procedure. According to her, the third respondent seemed 'a little unreliable regarding her health and life care' as is evident from her history. When seen by the doctor, the respondent had had a miscarriage, a HIV-infected baby, and many children at her advanced age, and was once again pregnant despite her own HIV status. The doctor felt that the respondent would be ‘best helped’
if she did not fall pregnant again.

[82]
The doctor added that the health passports
were used by doctors to communicate with each other, because patients attending state hospitals did not have the right to choose their doctors, and whichever doctor was on duty would be allocated to assist them. She confirmed that the Katutura State Hospital was extremely busy with approximately 6000 child deliveries each year. Approximately 2500 births take place annually at the Windhoek Central Hospital, also a state hospital. At Katutura State Hospital, delivery rooms were so full that occasionally some deliveries took place outside those rooms.

[83]
Dr Krönke attended to the respondent
again when she went into labour. She told the Court that under normal circumstances, sterilisation could be performed 48 hours or six weeks after the patient had given birth. When she gave birth, the third respondent had been waiting for a normal delivery but because she was not ready, the doctors, in consultation with the nurses, assessed her and decided to perform a caesarean section. The respondent was then counselled with the assistance of an interpreter. Dr Krönke said

that the doctors typically spoke to each other in English, but would use an interpreter when communicating with a patient who did not understand English.

[84]
In cross-examination, Dr Krönke agreed
that sterilisation was an invasive procedure. She added though that it could also be 'very invasive if a patient falls pregnant when it would be a disaster to her health'. When questioned by counsel for the respondents on her understanding of the concept of 'paternalism', she defined the phrase as meaning displaying too much authority and compelling a patient to make a certain decision. However, she explained that this was not the manner in which the respondents had been cared for. The doctor emphasised that the decision about what should happen to a patient ultimately lay with the individual, adding, however, that it was possible that patients may feel intimidated if the doctor gave them information on all the risks involved in making a particular medical decision.

[85]
Dr Krönke also said that a pregnant
woman had the option of involving her partner in deciding whether or not to consent to elective sterilisation, but that this was not a legal requirement. She agreed that the standard for consent for an operation was informed consent. She appears to have agreed that a patient should not be counselled for the first time about sterilisation while experiencing active labour. The witness also testified that she was not involved in obtaining the third respondent’s consent for the operations and that counselling was done at the antenatal care clinic. In order for the patient to give informed consent, she did not necessarily have to attend individual counselling. It would be sufficient if she understood all the information given to her during antenatal care group counselling. The explanations given at these sessions were conducted in layman's terms and in a manner that could be understood by everyone. She agreed that if a patient opted for sterilisation, the health professional must be satisfied that the patient understood the entire process and its consequences.

[86]
Dr Krönke told the court that the
third respondent had six months after her initial visit to the doctor to consider and decide whether or not to be sterilised. The witness said that bookings were done for elective caesareans but not for sterilisation procedures. Many women who elected to be sterilised did not attend to make bookings, but this did not necessarily mean that they no longer wished to be sterilised. The doctor 'strongly believed' that the respondent was considering sterilisation before she went into labour.

[87]
The doctor agreed that if sterilisation was
discussed with a patient for the first time during active labour, her consent for the procedure should not be accepted. 'Active labour' refers to the contractions experienced by the patient shortly after early labour. It involves at least three contractions every ten minutes and the cervix is usually dilated six to ten centimetres.

[88]
Dr Krönke also noted that the
inscription 'BTL' is written on the front of a patient's health passport for the purpose of reminding doctors to perform the surgery, because many patients return to hospitals to complain that they became pregnant after they should have been sterilised. That concludes the rather long summary of the evidence. I turn next to the analysis of the evidence.

Analysis

of the evidence

[89]
It should be observed at the outset that
certain aspects of the respondents' evidence are entirely unsatisfactory. These relate to questions regarding whether they were seen by certain doctors and whether health personnel gave them information about various forms of contraception, including sterilisation. In respect of the third respondent, for example, I find that her denial that she had a consultation with Dr Iithete, who stated that he had spoken to her in her vernacular, is in all

probability false. It is equally difficult to accept the second respondent's assertion that she was not informed of contraceptive methods at antenatal classes or that she had been threatened by a doctor to undergo sterilisation. Her denial in cross-examination that she did not know the difference between reversible and irreversible sterilisation is equally unconvincing given her admission that she knew of such difference in her evidence-in-chief. In light of the concerns I have with some aspects of the respondents' evidence, I will approach the evidence and decide the appeal principally based on the testimonies of the appellant's witnesses and the evidence of Dr Kimberg. I find the evidence of those witnesses generally to be reliable. In the next section, I propose to examine more closely the factual position regarding the circumstances that led to the each of the respondents to sign the consent forms. That analysis will be followed by a consideration of the law on informed consent and its application to the factual matrix of the appeal.

First
respondent

[90]
It was agreed by both sides that first
respondent went to the hospital to have a normal natural birth and that she did not make a booking for either a caesarean or a sterilisation procedure. Although informed of sterilisation as part of a general antenatal care education, there is 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 eight hours. It was agreed that she would have been exhausted after being in labour for so long. Even assuming that she had requested to be sterilised, it was not the appropriate time to obtain consent to such an invasive and potentially permanent procedure as sterilisation, as set out in the evidence of Dr Kimberg, whose evidence I accept. The first respondent had, of course, consented to the caesarean procedure. The form which she signed, as earlier indicated, says that she was consenting to ‘caeser and BTL due to previous caeser’. Can it then be said that in those circumstances she has also consented to be sterilised? The answer in my view should be in the negative. The caesarean section was an emergency procedure that the doctors might have been legally entitled to perform even if the first respondent had not given her consent, provided, of course, that there were valid legal and medical grounds to do so. Moreover, the first respondent went to the hospital to be assisted to give birth and it must have been within her contemplation that an emergency such as the caesarean section may be performed on her should complications preventing the normal delivery arise. However, the possibility that she may undergo a sterilisation

procedure in those circumstances could not be said, by any stretch of imagination, to have been within her contemplation as a reasonable or natural consequence of the delivery.

Second
respondent

[91]
The evidence in respect of the second
respondent showed that Dr de Klerk, whom the second respondent consulted, confirmed that she wrote the inscription ‘BTL’ on the respondent’s health passport because that was the family planning method the respondent had opted for after counselling. Dr de Klerk explained that the second respondent had not agreed to the sterilisation but had instead only 'opted' for it, as she could only signify her consent by signing the consent form. Dr de Klerk added that the second respondent had accepted ‘sterilisation as a method of family planning for the future’ after delivery. The doctor reasoned that it was the responsibility of the doctors who would attend to the second respondent in future to confirm whether she still preferred to be sterilised. She also made it clear that the possible reversal of the sterilisation procedure would not have been discussed with the second respondent, nor would the risks associated with the procedure have been explained to her. The second respondent would, however, have been informed that sterility was the consequence of the procedure. Dr de Klerk made an important concession when she said that in the circumstances where the expression 'family planning: BTL' had been written on the health passport of a patient, a future health practitioner might assume that the sterilisation procedure had been previously discussed with the patient.

[92]
As it turned out, upon seeing the
inscription ‘BTL’ on the second respondent's health passport, Nurse Ndjalo, who prepared the second respondent for the procedures, in her own words 'assumed' that the respondent wanted to be sterilised. Nurse Ndjalo also speculated that she would have asked the second respondent whether she still wanted to go ahead with the sterilisation procedure and then proceeded to explain the consequences and risks of the procedure. Unfortunately, the alleged questions and explanations given to the respondent are not recorded anywhere in the clinical notes. Given Nurse Ndjalo's admission that she did not have a personal recollection of the second respondent, such assertions are again based on assumptions and therefore cannot be accepted as facts.

[93]
It is apparent from the second respondent's
evidence that she is the best-educated amongst the three respondents. She understood the meaning of sterilisation and the consequences thereof. It is also clear that she had opted for the procedure as a means of family planning after the delivery of her baby during her consultation with Dr de Klerk. Dr de Klerk was entirely correct in her observation that although the second respondent had opted to be sterilised, she still had to signify her acceptance of the procedure by signing the consent form. Although the respondent had apparently opted to undergo the procedure at some point in the future, it is clear that she did not book in for sterilisation. The second respondent was expected to give a normal natural delivery until it was discovered that the foetus was in a breech position. Whilst in labour, she decided to undergo an emergency caesarean section. Although she signed the consent form that had the inscription 'BTL' on it, such consent was given at the height of labour. In my view, the position of the second respondent is no different from that of the first. Although the second respondent had evidently opted for sterilisation at some time in the future, she still had the opportunity to change her mind and her consent should not have been obtained at the height of labour when it was difficult to make a rational and informed decision.

Third
respondent

[94]
The third respondent was 46 years old at
the time of the procedure in dispute and at the end of her childbearing years. She had previously had seven pregnancies and undergone a caesarean section operation. The sterilisation procedure in her case was reversible. All these factors are relevant for consideration of damages.

[95]
As to the question of whether she had
consented to be sterilised, it is clear that the doctors felt that because of her circumstances, she was a suitable candidate for sterilisation and had recommended that she should consider undergoing the procedure. The inscription 'BTL' was written on her health passport only to remind doctors who would attend to her in the future to perform the operation if that was her ultimate choice. It is also clear from the evidence that Dr Krönke, who initially

recommended the operation, was not involved in obtaining consent for the procedure and assumed that counselling had been given at the antenatal clinic. Nurse Kamberipa, who gave the consent form to the third respondent, also assumed that the 'BTL' inscription on the respondent's health passport indicated that the respondent had agreed to be sterilised. It is also apparent from the record that the third respondent did not book in for sterilisation so as to record her intention to continue with the operation. In fact, the third respondent went to the hospital for a normal delivery and her situation changed only when she was not ready to give birth the following day. Only then did the doctors decide that a caesarean operation was necessary. There is no evidence that the third respondent had elected to be sterilised as a means of birth control. Like the first and second respondents, she signed the consent form only at the height of labour. Her position is thus no different from the rest of the respondents.

Informed consent

[96]
The Health Professionals Council of Namibia has published a document titled *Ethical Guidelines for Health Professionals.* This publication was submitted in evidence by the appellant. As previously mentioned, the health professionals who testified as witnesses for the appellant confirmed that the guidelines were of application to health professionals in Namibia. Chapter 6 of the *Guidelines* deals with the principles concerning the protection of rights and confidentiality of patients. Paragraph 2.8 under the heading 'Informed Consent' states that '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'.

[97]
The publication recognises the importance of the principles of informed consent and self-determination, stating a health professional should 'apply the principle of informed consent as an on-going process' and that he or she should 'honour patients' rights to self-determination or to make their own informed choices, living their lives by their own beliefs, values and preferences'.

[98]

In *Christian*

Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae) 2005

(1) SA 509 (T) the then Transvaal Provincial Division of the High Court of South Africa had occasion to consider informed consent in the context of the termination of a pregnancy. Mojapelo J, stated the following at 515D-I:

'The
concept is, however, not alien to our common law. It forms the basis of the doctrine of *volenti non fit injuria* that justifies conduct that would otherwise have constituted a delict or crime if it took place without the victim's informed consent. More particularly, day to day invasive medical treatment, which would otherwise have constituted a violation of a patient's right to privacy and personal integrity, is justified and is lawful only because as a requirement of the law, is performed with the patient's informed consent. See *Van Wyk v Lewis* 1924 AD 438 at 451; *Castell v De Greef* 1994 (4) SA 408 (C) at 425; *C v Minister of Correctional Services* 1996 (4) SA 292 (T) at 300, Neethling, Potgieter and Visser *Law of Delict* 3rd ed at 100-1; Neethling *Persoonlikheidsreg* 4th ed at 121-2. It has come to be settled in our law that in this context, the informed consent requirement rests on three independent legs of knowledge, appreciation and consent.

The
Courts have often endorsed the following statements by Innes CJ in *Waring & Gillow Ltd v Sherborne* 1904 TS 340 at 344 to found a defence of consent:

'(I)t
must be clearly shown that the risk was known, that it was realised, and that it was voluntarily undertaken. Knowledge, appreciation, consent - these are the essential elements; but knowledge does not invariably imply appreciation, and both together are not necessarily equivalent to consent.'

The
requirement of "appreciation" implies more than mere knowledge. The woman who gives consent to the termination of her pregnancy 'must also comprehend and understand the nature and extent of the harm or risk'. See *Castell v De Greef* (supra at 425); Neethling, Potgieter & Visser (op cit at 101) and Neethling (op cit at 122).

The
last requirement of “consent” means that the woman must
'in fact subjectively consent' to the harm or risk associated with
the termination of her pregnancy and her consent “must be
comprehensive” in that it must “extend to the entire
transaction, inclusive of its consequences”. *Castell v De
Greef* (supra at 425), Neethling, Potgieter & Visser (op cit
at 120) and Neethling (*op cit* at 122).’

[99]

The most important consideration that flows
from the above dicta is that in the context of a sterilisation, the
woman must in fact be in a position to comprehend the nature and
consequences of the operation to be performed on her. It follows that
the patient must have the capacity to give her consent for it to
amount to informed consent. In the *Christian
Lawyers Association* case it was further
stated at page 516B-C that:

‘In
this context, valid consent can only be given by someone with the
intellectual and emotional capacity for the required knowledge,
appreciation and consent. Because consent is a manifestation of will,
“capacity to consent depends on the ability to form an
intelligent will on the basis of an appreciation of the nature and
consequences of the act consented to.” Van Heerden and others
Boberg's Law of Persons and the Family
2nd ed
at 849.’

[100]

I respectfully agree with the above
observations. In the case before us, it is crucial to determine
whether the respondents had the intellectual and emotional capacity
to give their informed consent in the light of the peculiar
circumstances in which they found themselves when signing the consent
forms. The records of all three respondents do not indicate what
information was conveyed to the respondents when their written
consent was obtained. The witnesses for the appellant, however,
remained adamant that, regardless of the absence of any records made
that indicate what was said to the respondents, they would have
discussed the nature and risks of the sterilisation procedures. This
is despite the absence of any independent recollection of exactly
what happened in the process of treating each respondent and the
nature and extent of any explanations given at the time. In the
absence of any detailed clinical notes regarding what was explained
to the respondents about sterilisation, it was unsurprising that the
witnesses concerned proceeded from the assumption that they had

explained the nature and risks of sterilisation to the respondents just because either their signatures appeared on the consent forms or there were clinical notes bearing their handwriting. Such assumptions, however, are not borne out by the evidence.

[101]
As previously noted, Dr Kimberg testified that because of the particularly invasive nature of a sterilisation procedure and its potentially permanent effects, it is not advisable to obtain the consent of a pregnant woman while she is in labour. As already mentioned, he also testified that labour pains could be of such a severe nature that a woman may lose sense of reality and ‘grasp at straws’ to be relieved of the pain. In the case of an operation such as BTL, which has the consequence of rendering a woman incapable of bearing any future children if not done with reversal in mind, informed consent must not be obtained without ensuring that the woman is capable of giving it.

[102]
I did not understand the doctors who testified for the appellant to challenge Dr Kimberg's opinion in this respect. It can be accepted that the state of mind of the respondents at the time they signed the forms was not only affected by the labour pains but by other complications as well. The first respondent was diagnosed with CPD, the second respondent’s foetus was in a breech position, and the third respondent was in a prolonged first stage of labour. Both sides agree that as a consequence of these complications, the respondents had to undergo emergency operations and it is not seriously disputed that they were in varying degrees of pain at the time they signed the consent forms.

[103]
Dr Kimberg, on behalf of the respondents, testified that even if the respondents had received adequate counselling, he would have hesitated to perform the BTL procedure on any one of them, and would have opted instead for a less invasive procedure that did not have the permanent effects of the BTL procedure. The doctors who gave evidence on behalf of the respondents appeared to have formed the opinion that sterilisation was the best option available to the respondents, presumably because - as one of the doctors put it in relation to the third respondent - BTL would offer a 'final solution' to the respondents' predicament.

[104]

With great respect, this attitude smacks of medical paternalism. In *Castell v De Greef* above, the Full Bench of the Cape Provincial Division of the High Court of South Africa at 422G-423A endorsed a quote from an unpublished doctoral thesis by Van Oosten entitled: '*The Doctrine of Informed Consent in Medical Law'* which reads:

'When it comes to a straight choice between patient autonomy and medical paternalism, there can be little doubt that the former is decidedly more in conformity with contemporary notions of and emphasis on human rights and individual freedoms and a modern professionalised and consumer-orientated society than the latter, which stems largely from a bygone era predominantly marked by presently outmoded patriarchal attitudes. The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in a position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision whether or not to submit to the proposed intervention. But even where medical considerations are the only ones that come into play, the cardinal principle of self-determination still demands that the ultimate and informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor.'

[105]

I respectfully endorse these observations.

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 the doctors as being 'unreliable concerning her life care' and that it was felt that she is 'best helped if she never falls pregnant again'. As indicated earlier, the third respondent was also asked whether she had thought of 'the final solution' to her pregnancy in light of her age, and was advised to ensure that her pregnancy 'should be the very last in her life'. It may well be that the doctors' evaluation of the third respondent was medically correct and that the views expressed about her undoubtedly reflected a genuine concern for her well-being. However, by virtue of the application of the doctrine of informed consent, our law and the policies applicable to Namibian health professionals recognise that the patient has the final say in deciding whether or not she should undergo an elective medical procedure. This consideration, of course, does not find application in emergency situations as illustrated by

the facts in this case which show that it was necessary for the three respondents to undergo caesarean sections on the basis of well-established medical grounds.

[106]
There can be no place in this day and age for medical paternalism when it comes to the important moment of deciding whether or not to undergo a sterilisation procedure. The principles of individual autonomy and self-determination are the overriding principles towards which our jurisprudence should move in this area of the law.[4] These principles require that in deciding whether or not to undergo an elective procedure, the patient must have the final word. Unlike some life-saving procedures that require intervention on a moment's notice, sterilisation allows time for informed and considered decisions. It is true, as already mentioned, that health professionals are under an obligation to assess the patient and point out the risks involved in particular procedures so as to enable the patient to make an informed decision and give informed consent. They may also make recommendations as to the management and/or treatment of a patient's condition based on their professional assessment. However, the final decision of whether or not to consent to a particular procedure rests entirely with the patient. I emphasise that the term 'procedure' referred to here must not be understood as including emergency operations or procedures that doctors are obliged to perform on patients even without their consent if legal or medical grounds have been established.

[107]
It is therefore my considered opinion that the doctors should not have sterilised the respondents because of the circumstances in which the consent was obtained. I am not persuaded that the appellant has discharged its onus of demonstrating on the balance of probabilities that informed consent was given by any of the respondents. The respondents should have been given an opportunity to return to hospital at a later stage to undergo the BTL procedure, after having had the opportunity to make an informed decision in a sound state of mind and without being influenced by circumstances such as the labour pains they were experiencing at the time they signed the consent forms. It is possible at least in theory for the respondents to undergo procedures for them to bear children again, but, as was pointed out in evidence, such procedures remain beyond the reach of the majority of women in Namibia.

[108]
The consent obtained was invalidated by the
respondents' lack of capacity to give informed consent in light
of the history of how the decision to sterilise them was arrived at
and the circumstances under which the respondents' consent was
obtained. It was merely written rather than informed consent, which
in my opinion is not sufficient for the performance of a procedure as
invasive and potentially irreversible as sterilisation. The important
factor which must be kept in mind at all times is whether the woman
has the capacity to give her consent for sterilisation at the time
she is requested to sign consent forms. Therefore, it is not decisive
what information was given to her during antenatal care classes or at
the moment she signed the consent form if she is not capable of fully
comprehending the information or making a decision without any undue
influence caused by the pain she is experiencing.

[109]
For all these reasons, it is my considered
opinion that none of the respondents gave informed consent because
they were in varying degrees of labour and may not have fully and
rationally comprehended the consequences of giving consent for the
sterilisation procedure. This is especially the case given that none
of the respondents made any appointment or booking to confirm their
intention to be sterilised before going into labour.

[110]
In my view, the appeal in respect of each
of the respondents ought to be dismissed and the matter referred back
to the High Court for the determination by that court of the quantum
of damages payable by the appellant.

Costs

[111]
Counsel appearing for the respondents
argued the appeal on instructions from the Legal Assistance Centre

(LAC) and has informed us that in the light of the LAC's legal status, she was instructed not to ask for a costs order. Therefore no order as to costs will be made.

Order

[112]
The following order is made:

1.
The appeal in respect of each of the respondents is dismissed.

2.
The matter is remitted to the High Court for the determination of the quantum of damages.

3.
No order as to costs is made.

SHIVUTE
CJ

MARITZ
JA

MAINGA
JA

APPEARANCES

APPELLANT:

TJ Bruinders, SC

Assisted

by E Schimming-Chase

Instructed

by Government Attorneys

RESPONDENTS:

N Bassingthwaighte

Instructed

by Legal Assistance Centre

[1]

Article 8(1).

[2]

Article 8(2)*(b)*.

[3]

Article 14(1).

[4]

Cf. The remarks of Ackerman J in *Castell*
v
De
Greef
above at 426.

Gawanas v Government of the Republic of Namibia (SA-2009/27) [2012] NASC 1 (03 April 2012);

Supreme Court

LM and Others v Government of the Republic of Namibia (I 1603/2008 I 3518/2008 I 3007/2008) [2012] NAHC 211 (30 July 2012);

High Court

Government of the Republic of Namibia v Getachew (SA-2006/21) [2008] NASC 4 (15 April 2008);

Supreme Court

Government of the Republic of Namibia and Others v Katjizeu and Others (SA-2013/7) [2014] NASC 17 (29 October 2014);

Supreme Court

Naruseb and Others v Government of the Republic of Namibia and Another (APPEAL-2014/12) [2014] NAHCMD 74 (19 February 2014);

High Court Main Division

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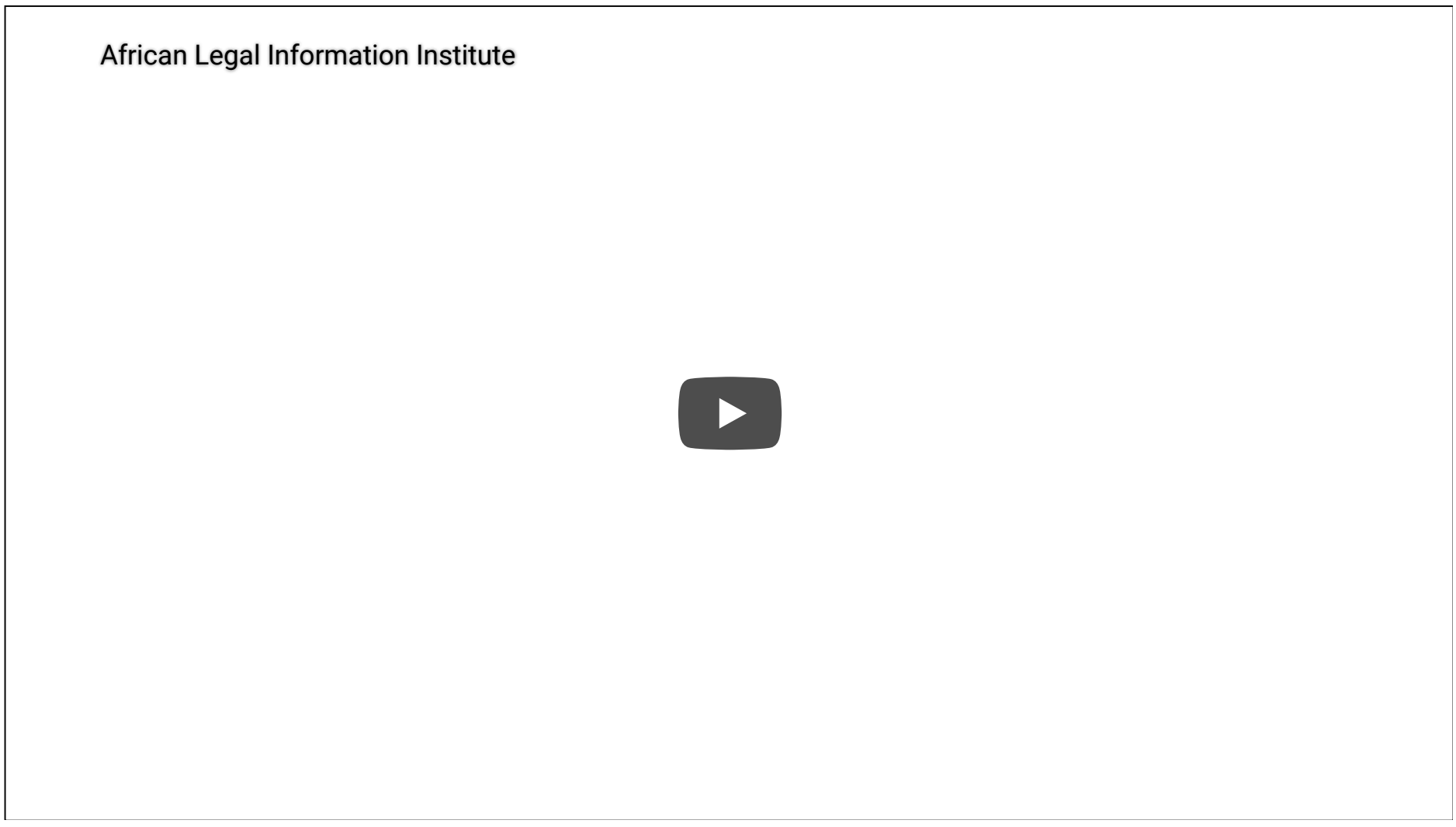

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