CASE NUMBER SA 49/2012

IN THE SUPREME COURT OF NAMIBIA

In the matter between:

GOVERNMENT OF THE REPUBLIC OF NAMIBIA	**APPELLANT**
and	
LM	**1ST RESPONDENT**
MI	**2ND RESPONDENT**
NH	**3RD RESPONDENT**

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1. RESPONDENTS HEADS OF ARGUMENT

Dated at **WINDHOEK** on this 03rd DAY OF MARCH 2014

LEGAL ASSISTANCE CENTRE

Per: _____

(Plaintiff's Legal Practitioners)

4 Korner Street

WINDHOEK

(REF: CJ VAN WYK)

particularly when utilising only acronyms such as BTL – were inadequate in the context of securing informed consent from a patient. We submit that it is clear that the entire concept of informed consent was not properly regarded by the medical staff in question at the Oshakati State hospital when it came to the first plaintiff's procedures. This is also borne out by their entirely inadequate recordkeeping.[37]

49.

First plaintiff testified that the manner in which Nurse Angula spoke to her was very forceful and she at the time felt that she would have no choice in the matter. She gave her forms to sign whilst she was lying on a stretcher. The nurse did not tell her what she was signing for.[38]

50.

Dr Kimberg testified that it is highly undesirable to obtain the consent of a patient during labour. In the particular circumstances of the first plaintiff his opinion was that even if she requested the procedure, the doctor would be acting irresponsibly if he were to accede to the request at that time, especially given her age. The doctor should rather advise that she come back after six weeks if she still wanted to have the sterilisation procedure. The reason why he considered it undesirable (which is also supported by literature) is because a woman in labour can be so overwhelmed by the pain

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[37] Exh Rec Vol 1 p18; Rec Vol 7 p808 ℓ18-25; Vol 14 p1610 ℓ1-10; p 1611; p 1622-1626; Vol 15 p 1697-1699

[38] Rec Vol 8 p 911 ; 1-10

that she loses a sense of reality. She could become so consumed by the pain that she would stop thinking rationally and would grab at any straw in the moment to be relieved of the pain. Dr Kimberg testified that, in his experience, many women at the height of labour say that they will never go through it again, yet would return with a pregnancy the next year.[39]

51.

His evidence to this effect was not disturbed in the course of a lengthy and detailed cross-examination.

52.

Defendant's witnesses (Dr Mavetera included) agreed with Dr Kimberg's opinion as to the undesirability of obtaining a patient's consent during labour.[40]

53.

Dr Krönke testified that the decision should be made during the pregnancy and that it would only be necessary to confirm the consent and obtain the signature prior to the operation. She stressed that the option of a sterilisation should not be put to a patient in labour for the first time.[41]

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[39] Rec Vol 10 p 1157

[40] Rec Vol 14 p 1632 ℓ 1-20

[41] Rec Vol 16 p 1823 ℓ 10-15; Rec Vol 16 p 1852 ℓ 1-20

54.

Dr Kimberg also testified that a sterilisation is contra indicated for women under the age of 30. This was also accepted by Dr Mavetera as a general proposition.[42]

55.

Dr Kimberg's opinion in this regard is also supported by the literature discovered by the defendant.[43]

56.

In Dr Kimberg's opinion, a patient such as first plaintiff should have been advised to rather return after 6 weeks for the sterilisation to give her time to consider her decision properly. This would also be the approach of Dr Krönke. This, we submit, is what should have happened. The events leading up to the operation are significant in this regard.[44]

57.

When it was put to Dr Mavetara under cross examination that he should rather have advised a patient such as the first plaintiff to come back for the sterilisation after 6 weeks, he said that it is what they would normally do but he cannot recall whether it was done in this case. When the same question was put to Nurse Angula her response was "WHY? as a sterilisation can be

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[42] Rec Vol 10 p 1170 ℓ 19-24; p 1171 ℓ 1-21; Rec Vol 14 p 1652 ℓ 19-21

[43] Rec Vol 2 p 192

[44] Rec Vol 10 p 1164 ℓ 23-30

done at any time and why should she be sent away just to be operated a second time". In light of Nurse Angula's response, it must be accepted that first plaintiff was clearly not advised to return after 6 weeks. If this was indeed the normal procedure, Nurse Angula would have said that it would have been done.[45]

58.

Dr Mavetera accepted under cross-examination that what is required from a patient is informed consent, not merely written consent.

59.

Dr Kimberg testified that in respect of first plaintiff he found (after doing a laparoscopy) that the fallopian tubes had been effectively blocked but that it was done so close to the ends of the tubes (the fimbria) which had resulted in fibrosis and distortion of the fimbria which gives a very poor prognosis for surgical reversal.[46]

60.

He testified that the sterilisation was not done with possible future reversal in mind.

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[45] Rec Vol 14 p 1652 ℓ 22-30

[46] Rec Vol 10 p 1130 ℓ 20-26; ℓ 30-31; p 1131 ℓ 1-4

61.

We submit that the first plaintiff's evidence is corroborated in all material respects by the contemporaneous notes which form part of her medical record. Plainly, she had not attended at the hospital for the purpose of any elected procedure. Had she formed an intention prior to going into labour to have a sterilisation – which is entirely unsupported by the contemporaneous notes, then she would have attended at the clinic for a booking. Her evidence as to what transpired with regard to signing the consent form would, we submit, be accepted. The contemporaneous notes concerning the time span in which a proper explanation should have been given and the like, again do not support the evidence of the health professionals called by the defendant and strongly support the evidence of the first plaintiff. Furthermore, Nurse Angula was constrained to concede that the inadequate record taking – and presumably also with regard to the inadequacy of any explanation prior to signing the form – was justified by reason of the emergency presented by the position of the foetus and the potential of serious danger to the unborn child.

62.

We submit that the defendant has clearly not discharged the onus of establishing informed consent on the part of the first plaintiff and that a principal claim has, upon the merits, been established.

Second plaintiff

63.

The second plaintiff gave birth by way of caesarean section on 9 December 2007 at Katutura State Hospital, Windhoek. At the same time a sterilisation procedure was performed upon her. Second plaintiff's claim is that such operation was performed because of her HIV positive status. It is the second plaintiff's case that she was coerced/forced to agree to a sterilisation procedure by a doctor who told her that he would not perform a caesarean section to assist her in the delivery of her baby who at the time presented in a breech position, if she does not agree to be sterilised.

64.

With regard to the second plaintiff the Hoff J found the following:

64.1. Although she knew what sterilisation is and understood that it would render her sterile permanently, knowledge of the nature and extent of the risk and an appreciation thereof does not equate informed consent as required.[47]

64.2. The "consent" was obtained in circumstances where she was not able to evaluate her choice. A patient must be informed of the alternatives available and the advantages and disadvantages of each at the time

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[47] Rec Vol 17 p 2055 para 69

the choice of sterilisation is made. This was not the case with second plaintiff. Furthermore, the explanation was given to her at the height of labour and in between contractions.[48]

64.3. The prior explanations given could not be regarded as sufficient to enable her to make an informed decision. The notes on the passport did not necessarily mean that she had made a decision and certainly does not mean she had been counselled, as conceded by Dr De Klerk.[49]

64.4. Nurse Ndjalo was instructed by doctor to only prepare the patient for a caesarean but when she saw inscriptions on passport, assumed that the second plaintiff wanted a sterilisation and that she had already been counselled. She claims to have given second plaintiff an explanation in between contractions.[50]

65.

Based on the above, and the evidence of Dr Kimberg as confirmed by a number of the defendant's witnesses, Hoff J found that the defendant on its own evidence, failed to discharge its onus.

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[48] Rec Vol 17 p 2055 para 70

[49] Rec Vol 17 p 2056 para 70

[50] Rec Vol 17 p 2056 para 70

66.

The defendant's case on appeal is that all that she needed to be informed of to make an informed decision (this is defendant's case in respect of all three plaintiffs) are the risks or consequences of a sterilization procedure. That is that it would render you sterile permanently. Defendant's case is that the plaintiff was so informed at an ante natal class on 12 September 2007 (which it claims Hoff J failed to consider because he failed to apply his own test of prior information) and by Doctor de Klerk on 26 October 2007. Defendant further states that the fact the second plaintiff signed her consent form whilst in labour does not mean that her consent was not informed because she had been informed of the risks and consequences of a sterilisation on a prior occasion. In this regard, the case is that Hoff J also failed to apply his own test.

67.

Firstly, the appellant misunderstands the test applied by Hoff J. He clearly stated that it is not sufficient for a patient to have knowledge of the nature and extent of the harm and risk and an appreciation thereof as far as a sterilisation procedure is concerned. At the time when a patient makes the decision whether to have a sterilisation, it is also important for a patient to be informed of the alternatives to sterilisation and the advantages and disadvantages of each. She must also be in a condition to evaluate and weigh up her choices. This would enable a patient to truly make an informed choice. It is submitted that this is the correct test based on the uncontested evidence of Dr Kimberg which was confirmed by the defendant's own

witnesses and the applicable authorities and literature, some of which was discovered by the defendant.[51]

68.

We further submit that despite the criticism levelled against the second plaintiff's evidence, the defendant on its own evidence and the medical records failed to discharge its onus as measured against the applicable standards.

69.

The second plaintiff did attend ante natal classes. But there is no record in her passport that she was given information about family planning, or on the sterilisation procedure for that matter. On 12 September 2007 the following inscription appears

> "group education given on routine ANC – care, breastfeeding PMTCT and HIV/AIDS" [52]

70.

This does not give the reader the impression that the second plaintiff was properly informed of family planning and in particular, sterilisation. In fact the plaintiff testified that this was her first ante natal visit and they were only told

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[51] Rec Vol 17 p 2055 para 70

[52] Exh Rec 1 p 90

about being clean and that they talked about personal hygiene in a group session.[53]

71.

The next inscription appears on 26 October 2007 when the second plaintiff saw Dr de Klerk who then recorded "Family Plan: BTL". With regard to this inscription it was put to the second plaintiff that other health workers would understand it to mean that family planning and sterilisation was discussed with her. It was never put to the second plaintiff that she made the choice on that day and that was also not the defendant's case in the court *a quo*. This is made for the first time on appeal.[54]

72.

The only other place in the second plaintiff's ante-natal care record where sterilisation is mentioned is on the front page / cover of the card. This inscription was also made on 26 October 2007 by Dr de Klerk at the PMTCT Clinic. The PMTCT programme is explained as being a programme which was introduced by Government for purposes of preventing mother to child transmission of the virus. All pregnant women who are found to be HIV positive are put on this programme specifically to make sure that they are advised appropriately for purposes of reducing the chances of transmitting the virus to the unborn child.[55]

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[53] Rec Vol 17 p 917 ℓ 20-24

[54] Rec Vol 8 p 924 ℓ 12-15; p 927 ℓ 10-18; Vol 9 p 941 ℓ 4-10; Exh Rec Vol 1 p 91

[55] Exh Rec Vol 1 p 89; Rec Vol 13 p 1473 ℓ 5-10

73.

Dr de Klerk testified as to what transpired on 26 October 2007. It must be pointed out at this stage already that this specific evidence was not put to the second plaintiff during cross-examination. The issues surrounding the inscription made on 26 October 2007 were only put to her in general terms.

74.

Dr de Klerk described in detail the usual process she engaged in at the PMTCT Clinic when a patient sees a doctor and she also explained her inscriptions. Dr de Klerk testified that the inscription made on 26 October 2007 which reads:

> "Family plan – BTL"

indicates that the second plaintiff "opted" for a sterilisation as a method of family planning after the birth of the child. She testified that she would have discussed family planning in general with the patient and would have referred her to the different options such as the pill, injection, intra-uterine device and sterilisation. All these options would have been discussed in relation to the patient's CD4 count and the medication that she may be taking because some options do not work very well if the patient is taking anti-retroviral drugs, such as the pill.[56]

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[56] Rec Vol 13 p 1473-1478

75.

Sterilisation would have also been explained as an option of family planning and Dr de Klerk testified that it would have been discussed in layman's terms to make sure that the patient understands and she would in fact have been informed that she would be closed and that she would no longer be able to have children and that she would not need to use any of the other contraceptive family planning methods. If the patient opted for sterilisation she would have made the inscription as appears in the second plaintiff's ante-natal care record. This is also what she testified happened and this is why the inscription reads as indicated. She also wrote "BTL" on the front page of the ante-natal care record in order to draw it to the attention of the ante-natal care clinic because the two clinics are different and are there for different purposes.[57]

76.

Dr de Klerk made it clear that the patient would still have time to go home and consider the option that she had chosen and could come back and inform the medical staff that she has finally decided on a particular option or whether she has changed her mind.[58]

77.

During cross-examination it was put to Dr de Klerk that the inscription may be interpreted differently by another health professional. It was put to her

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[57] Rec Vol 13 p 1480-1481

[58] Rec Vol 13 p 1481 ℓ 16-30

that another health professional may have read it as meaning that it is something which was merely raised with the patient or recommended to her. It would not necessarily be read as an accepted option. After much debate around this issue, Dr de Klerk conceded that the visit in question was a visit to the PMTCT Clinic which has a different objective to an obstetrical visit. Although family planning was discussed at the PMTCT Clinic, an indication regarding family planning would not necessarily be considered as final and that the patient would not have finally agreed to have a sterilisation procedure because she had not given her written consent to the procedure being done. She also acknowledged and accepted that the fact that the patient may have "opted" at the time for sterilisation as a family planning method cannot be relied on for purposes of claiming that she had given her informed consent to the sterilisation procedure.[59]

78.

Dr de Klerk added that before the procedure is to be performed the patient would have to have a discussion on how the procedure is done, what the risks are that are involved and what the consequences of the procedure would be. It is only once this has been done and she had agreed to the procedure that she would sign the consent form. The purpose of the discussion she had with the patient was for purposes of giving her information about family planning and to spell out the different options available. These issues, such as risk, the possibility of reversal etc (and

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[59] Rec Vol 13 p 1486 ℓ 24-31; p 1490 ℓ 20-30 – p 1491 ℓ 1-30

central, we submit, to informed consent) would not be part of the discussion. The patient would however know that she would not be able to have anymore children after the procedure.[60]

79.

Dr de Klerk was also asked whether if she was the surgeon performing the procedure she would have been satisfied if the patient signed a consent form at their discussion that she had obtained informed consent. Dr de Klerk's response was that she would not have been satisfied and that there was more that was needed than the discussion she had with the patient. Thus the information provided by Dr de Klerk was not sufficient, as measured against the required standard.[61]

80.

The only booking made for the second plaintiff was for a caesarean section for 10 December 2007 after she was seen by Dr Gurirab on 6 December 2007 because the baby presented in a breech position. Prior to that, there is no other record of sterilisation or that she should be booked for a caesarean in order to have a sterilisation performed at the same time. This clearly indicates that second plaintiff had not made a choice to have a sterilisation. If the issue had been raised at an ante natal class (where the decision should have been made) it would have been recorded and a

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[60] Rec Vol 13 p 1492 ℓ 10-30

[61] Rec Vol 13 p 1493 ℓ 27-30

booking would have been made. The only reason why she was referred to Dr Gurirab is because the baby was breech.[62]

81.

The second plaintiff testified that during one of her usual follow-up ante-natal care sessions on 6 December 2007, the nurse who examined her found that the head of the baby had not turned downwards and referred her to a doctor.[63]

82.

The doctor performed a sonar examination and found that the baby was in a breech position which means that instead of the head being downwards, the legs were facing down. Although the second plaintiff did not know the doctor who examined her, it is clear from the inscription in her ante-natal care record that the doctor was Dr Guirirab who also testified and confirmed this fact.[64]

83.

The second plaintiff testified that the doctor informed her about the fact that the baby was in a breech position and that he advised that she give birth by way of caesarean section because of the fact that she had her second child through a caesarean section and because of her HIV positive status. This

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[62] Exh Rc Vol 1 p 94

[63] Rec Vol 8 p 867 ℓ 16-20

[64] Rec Vol 1 p 94; Rec Vol 8 p 867 ℓ 23-30; p 168 ℓ 10

evidence was not disputed by Dr Guirirab. The second plaintiff however added that the doctor also informed her that she had to undergo a sterilisation at the same time. The second plaintiff testified that although the doctor did not shout he spoke firmly and she understood him to mean that she should agree to the sterilisation otherwise he would not perform the caesarean section.[65]

84.

The second plaintiff understood what the doctor meant when he said that she should be sterilised because she had already read the term in books at school and understood that it meant that she was not going to have any more children.[66]

85.

The second plaintiff said that the doctor did not ask her whether she wanted to have anymore children nor did he explain the consequences of sterilisation or any alternatives to sterilisation.[67]

86.

The second plaintiff testified that although she did not want to be sterilised she did not ask the doctor any questions or say that she did not want to be

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[65] Rec Vol 8 p 870-874

[66] Rec Vol 8 p 871 ℓ 24-30

[67] Rec Vol 8 p 872

sterilised because she was afraid that if she did not agree to the sterilisation he would not book her for the caesarean section.[68]

87.

During cross-examination the second plaintiff was asked why she did not tell the doctor that she did not want to be sterilised. Her response was that patients at the Katutura Hospital have no right to question doctors or nurses because in her experience if you were to dare to ask a nurse or a doctor any questions they would admonish and shout at you in front of other patients.[69]

88.

Dr Guirirab stated in his evidence that he examined the second plaintiff on 6 December 2007 and recorded the notes in her ante-natal care record. He testified that the patient was sent to him for confirmation of a breech presentation which confirmation he made after performing a sonar. He testified that he advised her that she should have a caesarean section. Although he cannot recall what happened, he said that in a scenario such as the one presented on 6 December 2007 he would have explained to the patient that a caesarean section is a surgical procedure which comes with its own inherent risks regarding anaesthesia and the procedure itself. He would have also explained to her what the situation would be after the surgery and the time that she would need to spend in the hospital and any medication she might need to take. Dr Guirirab could not say whether he had looked at

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[68] Rec Vol 8 p174

[69] Rec Vol 9 p 948 ℓ 12-19

the full ante-natal care record from what he sees in his notes. He could also not say whether he was aware of the fact that the second plaintiff was indeed HIV positive at the time when he did his observations if he only were to have regard to his notes.[70]

89.

During cross-examination Dr Guirirab acknowledged the importance of making a full record of the examination and what was told to the patient specifically because he would not have any independent recollection of a specific patient due to the workload at the State Hospital and that his explanation regarding the nature of the caesarean section and the possible consequences of such a procedure should have been reflected in his notes which he did not do.[71]

90.

Dr Guirirab also testified under cross-examination that he does not think that he would have mentioned sterilisation because he did not record it in his notes. He considers sterilisation to be a very serious procedure and although he cannot exclude the possibility that he could have raised it with her, if one has regard to the fact that he did not note other aspects of his examination, Dr Guirirab insisted that the fact that he did not note anything

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[70] Exh Rec Vol 1 p 94

[71] Rec Vol 14 p 1573 ℓ 1-20

about a sterilisation is an indication that he did not mention it to the patient at the time.[72]

91.

During re-examination Dr Guirirab also said that he would never have said to a patient that if she does not agree to a sterilisation he would not book her for a caesarean because it goes against him being a doctor which is to help patients to the best of his ability and it would not have been beneficial to the patient to do that because she would then have been denied a lifesaving operation.[73]

92.

It is however common cause that the second plaintiff was booked only for a caesarean section on 10 December 2007.[74]

93.

There are a number of possible inferences that one can draw, even to the exclusion of the second plaintiff's evidence. The first conclusion is that the issue of sterilisation did not come up at all in the conversation as there is no reference to it at all. This means that there was no explanation whatsoever given by Dr Gurirab as far as sterilisation is concerned. It also explains why he only booked her for a caesarean. This version is certainly borne out by

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[72] Rec Vol 14 p 1575 ℓ 1-16

[73] Rec Vol 14 p 1581 ℓ 1-15

[74] Exh Rec Vol 1 p 94

the medical evidence. It could be that the second plaintiff in this regard was confused about when and by whom the issue of a sterilisation was raised with her (she was seen by a doctor prior to her delivery that actually made reference to "BTL" on her medical record. This could possibly be the doctor who told her that she would be sterilised). It is also possible that the issue was raised with the second plaintiff and not noted because it was already noted on the cover of her health passport. Dr Gurirab admitted that he did not note all aspects of what he would have discussed with the second plaintiff. In this scenario it is certainly possible that the second plaintiff's evidence of the events are correct.

94.

The fact is, whichever scenario one accepts, the objective evidence shows that the second plaintiff on this day did not make a choice to have a sterilisation. She was not counselled as required and could thus not have given her informed consent with reference to her discussion with Dr Gurirab.

95.

It is also common cause that the second plaintiff started having contractions on 8 December 2007 and an emergency caesarean section was performed on 9 December 2007.

96.

The second plaintiff testified that the contractions started around 3 o'clock on 8 December 2007 but were not very severe at the time. She waited until

about 8 o'clock when she felt that the contractions were becoming stronger. Her boyfriend then took her to the hospital where she was told to lie down on a bed. She was only admitted later on during that evening. According to the maternity record the second plaintiff was admitted at around 23h44.[75]

97.

The second plaintiff testified that she was already in severe pain at the time and that this fact should have been evident even from her demeanour. Her condition was also recorded in the maternity record where it was indicated that she was having three contractions every 10 minutes for about 30 to 35 seconds. She was already 3 to 4 cm dilated.[76]

98.

It would appear from the maternity record that the second plaintiff was next assessed at around 12h39 and that she was at this time already in acute labour. It was put to the second plaintiff under cross-examination that this inscription was made by Dr Shanyenga who examined her.[77]

99.

Although the second plaintiff could not say whether it was a doctor who examined her, she mentioned that the person was wearing green clothes and that the person was only writing and asking questions from the student

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[75] Rec Vol 8 p 875 ℓ 1-2; Rec Vol 1 p 48

[76] Rec Vol 1 p 48; Rec Vol 8 p 876 ℓ 8-11

[77] Exh Rec Vol 1 p 47-48; Rec Vol 9 p 960 ℓ 29-30

nurse. After this person left a nurse came to her and told her she must sign two documents. The second plaintiff asked the nurse what the documents were for and the nurse simply told her that the doctor already explained to her, she must just sign. The second plaintiff could not say exactly at what time she signed the documents but that there was not much time between the time that she signed the documents and when she was taken to the theatre. She could recall that the nurse was in a hurry and in fact told her to hurry and sign the papers.[78]

100.

The second plaintiff testified that she signed the two forms being the form headed "Consent to an operation" and the one with the heading "Consent form for sterilisation". She said she did not read the forms. Nor were they read or explained to her by the nurse. The second plaintiff testified that she did not read the forms although she can read English because she was in too much pain at the time and was not given an opportunity to read the forms.[79]

101.

It is not clear from the two consent forms at what time they were signed. They would however have been signed sometime between 00h39 and 01h00 which is the time when the operation commenced.

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[78] Rec Vol 9 p 961 ℓ24-32 – p 962 ℓ1-14

[79] Rec Vol 9 p 963 ℓ 10-15; ℓ 20-25; Exh Rec Vol 1 p 53-54; Exhibits C7 and C8

102.

Nurse Ndjala testified that she prepared the second plaintiff for her operation and also obtained her signature on the two consent forms. She testified that she would have explained to the second plaintiff that she was going to be sterilised, that she would not be able to have any children in the future and that she cannot come back to be operated so that she can have children. She would then have asked the second plaintiff whether she understood and once she agreed, she would have given her the forms to complete.[80]

103.

According to Nurse Ndjala the second defendant wrote her name on the forms and also signed in the space indicated after she had given an explanation to her. When she was asked how she could have given the explanation whilst the second plaintiff was in labour, she testified that labour is not continuous and that she would have explained during the intervals when there were no contractions and would stop when the patient was having a contraction. She would then continue when the contractions stopped.[81]

104.

During cross-examination Nurse Ndjala testified that she read the second plaintiff's ante-natal care record and when she saw the inscription on the front page of the record where it is written "BTL" and another inscription on

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[80] Rec Vol 13 p 1514 *l* 14-25

page 3 of the ante-natal care record where there is a reference to "Family plan: BTL" she assumed that the second plaintiff wanted to be sterilised (this contradicts what was put to second plaintiff under cross – examination as to the evidence which would be given by Nurse Endjala on how she would understand the inscription) and that she was already counselled (it was put to the second plaintiff that the evidence would be that it was discussed with her). She would have asked the patient herself because she just wanted confirmation that she really wanted sterilisation.[82]

105.

It was put to Nurse Ndjala that the instruction which was given to her by the doctor on 9 December 2007 according to the notes recorded on the maternity record, is that she was to prepare the patient for a caesarean section only, there being no reference to a sterilisation. It required several repetitions of the same questions before Nurse Ndjala admitted that was the instruction that was given to her. This was but one of the several unsatisfactory features of her testimony.[83]

106.

Nurse Ndjala also accepted that if the doctor instructed her to prepare the patient for something other than the caesarean section, such as a sterilisation, the doctor would have written it down. She furthermore

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[81] Rec Vol 13 p 1515 ℓ 15-25

[82] Rec Vol 13 p 1578 ℓ 4-17; ℓ 22-30

[83] Rec Vol 13 p 1520 ℓ 8-14

acknowledged that in this case the doctor did not instruct her to prepare the patient for a sterilisation.[84]

107.

It appears from the evidence of Nurse Ndjala that she accepted that second plaintiff had already received counselling regarding the sterilisation procedure during the ante-natal classes and did not consider it necessary to counsel her again or to ask her whether she wanted her partner present to make a decision whether she wanted to be sterilised. She testified that all she needed to do at the time was to obtain confirmation from the second plaintiff as to whether she would still stick to a decision to have a sterilisation and for that reason she asked her this question and whether she understood. Nurse Ndjala also testified that she would have explained the consent forms to the second plaintiff before she signed the forms. When the second plaintiff's version was put to her, Nurse Ndjala denied that she compelled or coerced the patient into having a sterilisation. She testified that the second plaintiff would have decided on her own and that she would have requested to be sterilised.[85]

108.

It was pointed out to Nurse Ndjala during cross-examination that the last inscription by the doctor before the second plaintiff came in for the delivery, was that she is to be booked for a caesarean section on 10 December 2007.

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[84] Rec Vol 13 p 1524-1525

[85] Rec Vol 13 p 1532-1533; p 1539 ℓ 15 – p 1541; p 1550 ℓ 258 – p 1551 ℓ 16

There was no reference to a sterilisation or BTL and if the doctor had wanted a sterilisation to take place he would have entered it there. Nurse Ndjala's response was that she did not have an answer for the question. It was then put to her that the evidence of the second plaintiff was that the reason why she was told that she would have to have a sterilisation is because she was HIV positive. Nurse Ndjala responded that she has never heard of a person being sterilised because she is HIV positive.[86]

109.

At the time when the second plaintiff's consent was obtained she was in labour and was experiencing severe pain. It is highly improbable that Nurse Endjalo, considering her workload, would have stood there and explained the sterilisation procedure, bit by bit, in between contractions, waiting for a contraction to finish before continuing with the explanation. Her reliance on the inscriptions in the passport to make certain assumptions, contrary to what was put to second defendant would've been the assumptions, was clearly wrong under the circumstances. It is therefore submitted that the defendant failed to discharge its onus in respect of the second plaintiff. We submit that the defendant has not discharged the onus of establishing informed consent on the part of the second plaintiff. Her statement that she agreed to the procedure under duress would appear to have been with reference to Dr Kleophas.

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[86] Rec Vol 13 p 1524-1525; p 1550 *l* 10-17

Third plaintiff

110.

The defendant's case as far as the third plaintiff is concerned is that she was informed of the risks and consequences of a sterilisation at a gynaecological consultation with Dr Kronke on 30 March 2005 and that it is more probable than not that it was canvassed in ante natal classes. Sterility is not a consequence in her case because there is a good prognosis of reversal in her case. (This was not the case in the High Court). Due to her age and the number of children she has, she was unlikely to have another pregnancy due to her age. The defence case is further Hoff J failed to answer the question before him, i.e. whether third plaintiff was informed on a prior occasion of the risks and consequences of a sterilisation.

111.

It is submitted with respect that the primary harm to the plaintiff is the fact that she was sterilised without her consent. Whether the sterilisation is permanent or reversible is a question of the extent of the damages which she would be entitled to at the end of the day. This is not an issue which needs to be considered at this stage. This is also the case as far the issue of whether she should or could still have children at her age and with the number of children she already has.

112.

The idea of the sterilisation, at least as far as the health professionals involved were concerned, arose much earlier during the pregnancy in

respect of the third plaintiff. She on the other hand testified that she never understood that it was discussed with her or that it was recommended to her.

113.

On 10 March 2005 third plaintiff was taken to hospital by her partner because she was experiencing severe pain to the extent that she felt like she was going to die as a result of the pregnancy. She testified that the pain was so severe that she was unable to walk and had to be carried by her partner and a neighbour who assisted him to the car and thereafter had to be wheeled into the hospital on a stretcher.[87]

114.

The third plaintiff testified that she requested that the pregnancy be terminated (in her words "be removed") because she feared that she was going to die as a result of the pregnancy. It must be emphasized at this point already that the third plaintiff did not consider her request as amounting to termination of the life of her unborn child (as was repeatedly put to her during cross-examination) but rather as a termination of a pregnancy which was still in its earlier stages and appeared to her to constitute a threat to her life.[88]

115.

It is clear from the third plaintiff's evidence that she was examined by several doctors and was also taken for a sonar. She mentioned that she was

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[87] Rec Vol 9 p 992 ℓ 6-30; p 993 ℓ 1-20

examined by a white male doctor and that a white female doctor subsequently did a sonar. The third plaintiff testified that the conversation that took place around her was conducted in English and that none of the medical personnel spoke to her directly (but at best to her partner. She testified that the conversation took place between the health professionals amongst themselves and at some point between the health professionals and her partner. That this was her actual perception of what happened is highly probable considering the pain that she was in. Her partner eventually told her that the doctors said that the pregnancy is fine, that the baby is already big and that they as a result could not terminate the pregnancy. He also pointed to the sonar at the time when he informed her of this fact. This evidence is in material respects corroborated by the evidence given by medical personnel called on behalf of the defendant.[89]

116.

The third plaintiff testified that her partner, to her knowledge, understands some English, but can only speak a little. We submit that a great deal of important information may not have been passed on to the doctors. This would accord with the generally paternalistic attitude of most of the health professionals who testified for the defendant – repeatedly referring to their decisions in respect of patients.[90]

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[88] Rec Vol 9 p 993 ℓ 15-26

[89] Rec Vol 9 p 997 ℓ 26-32; p 998-999

[90] Rec Vol 0 p 1001 ℓ 25 – p 1002 ℓ 1

117.

The importance of proper and complete recordkeeping is best demonstrated by what happened in respect of the third plaintiff. Already from the first inscriptions one can see that the records kept by the health professionals are entirely incomplete and do not accurately reflect what actually transpired on 10 March 2005. This, we submit, ultimately resulted in other health professionals who treated the third plaintiff after 10 March 2005 assuming certain things which ultimately resulted in her being sterilised without her consent.

118.

If one has regard to the referral note written by Dr Ithete on 10 March 2005 and his inscription in her health passport, he left out one important detail and that is that third plaintiff actually requested a termination of the pregnancy, not because she was HIV and did not want anymore children, but because she felt that the pregnancy was threatening her life. He also did not note that she was in such severe pain and that she was unable to walk by herself. He correctly could not and did not dispute these issues. His notes only indicate that she requested a termination of pregnancy on medical grounds and that she had recurrent problems in her pregnancy. He also refers to her HIV status which, as appears below, resulted in some of the health professionals assuming that she wanted the pregnancy terminated because of her HIV status. The divergence between his evidence that he would have spoken in Oshiwambo in contrast to her evidence that she was only spoken to in

English, is not material. He conceded that he may have explained matters to her partner. Her state at the time is also relevant and material.[91]

119.

Everyone who treated third plaintiff subsequent to 10 March 2005 assumed that she wanted a termination of the pregnancy because she did not want to be pregnant due to, possibly her age, HIV positive status and the fact that she already had six other children. It is on this basis that Dr Krönke in actual fact recommended a sterilisation to the third plaintiff when she saw her subsequently. Dr Krönke in fact testified that she assumed that third plaintiff regarded this pregnancy as an unwanted pregnancy and for that reasons want it to be terminated and because of that assumption she found it reasonable to suggest a sterilisation which she considered to be what she termed "a final solution" for third plaintiff to avoid any further unwanted pregnancies. She testified that with her history third plaintiff is best helped is she never fall pregnant again. This also seems to be the basis of the argument of the defendant on appeal. In fact, the defendant misreads Dr Kronke's note. The note reads that third plaintiff "never thought about BTL after last delivery". The defendant states in its heads of argument:

> "Tellingly, the note by Dr Kronke says that the third plaintiff had used condoms with poor success and that she had thought about sterilization after her last delivery." [92]

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[91] Rec Vol 1 p 97 and p 102

[92] Rec Vol 16 p 1805 ℓ 22-31; p 1835 ℓ 1-32; Heads of Argument p 35 para 72; Rec Vol 16 p 1801 ℓ 1-16 (where Dr Krönke reads her inscription)

120.

The third plaintiff testified about a white female doctor who saw her on 10 March 2005 and also did a sonar. As far as she could recall, this examination by the white female doctor took place on the same day.[93]

121.

Dr Krönke testified that she assumes that she saw the third plaintiff on or about 30 March 2005 based on the notes contained in her health passport. She could not say whether it was on this specific day because she did not note the date and time that she saw the patient. This is an important detail which was yet again not recorded by a health professional.[94]

122.

Third plaintiff testified that no one had any direct conversation with her and that the doctors spoke English with her partner. She also denied that she had any discussion regarding sterilisation or a caesarean section with any doctor or health professional at any stage. If there had been anything conveyed to her, it was not understood by her – borne out by her observation concerning the delivery and not understanding the epidural anaesthetic administered upon her.[95]

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[93] Rec Vol 9 p 998-999

[94] Rec Vol 16 p 1800 ℓ 26-28; p 1832 ℓ 1-10; Rec Vol 1 p 104

[95] Rec Vol 9 p 1001 ℓ 18-29

123.

Dr Krönke testified that she would have advised third plaintiff to have a caesarean section firstly because of the many pregnancies she had and secondly because it is the safer option due to her HIV positive status. Clearly, if Dr Krönke had given such advice, it was not understood. She also testified that she would have recommended to the third plaintiff that she undergo a sterilisation at the same time that the caesarean section is done. According to Dr Krönke she would not have counselled the third plaintiff. However she says she would have told her that a sterilisation is a permanent solution which would result in her being unable to have any children. She also said that she would not have obtained an informed consent from third plaintiff at this stage which is a task which is normally delegated to other medical officers. She would also not explain alternatives and what risks there are such as anaesthetic risks. These would be delegated to a medical officer.[96]

124.

The only other inscription prior to the date on which the third plaintiff gave birth regarding a sterilisation appears in third plaintiff's ante-natal care record. Again the health professionals seemed to assume that the request for a termination of pregnancy was because of her HIV status if one has regard to the inscription which was made. An inscription was made on

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[96] Rec Vol 16 p 1802 ℓ 15 – p 1803 ℓ 27; Rec Vol 16 p 1824 ℓ 14-20; ℓ 30 – p 1825 ℓ 2

4 May 2005 that the plan for the third plaintiff was to have a caesarean section and a sterilisation.[97]

125.

None of the defendant's witnesses testified about the inscriptions made on 4 May 2005 except to say how they understood the inscriptions. When the third plaintiff was asked about this inscription and whether she at this stage consented to the sterilisation and caesarean procedures, third plaintiff denied that there was ever any such discussion or that she consented to the procedures.[98]

126.

It is clear that third plaintiff never intended to have the sterilisation despite the inscriptions on 30 March 2005, 4 May 2005 and the glaring note on the front of her ante-natal care record that she wants a sterilisation. Significantly, no booking was ever made for an elective caesarean section which is what would be required in respect of an elective procedure and was in fact said to be the meaning of an elective caesarean according to the evidence of Dr de Klerk and Dr Krönke.[99]

127.

One must assume that a booking for the caesarean section was never raised by any of the nurses at the ante-natal classes. There was no evidence to

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[97] Exh Rec Vol 1 p 110

[98] Rec Vol 9 p 1003 ℓ 1-9

[99] Exh Rec Vol 1 p 114

that effect and no note to that effect either. As far as third plaintiff was concerned she would be delivering naturally. Her contemporaneous conduct and her evidence forcefully corroborates that she never understood that she was to have an elective c/s (and certainly not a sterilisation). If a proper explanation was given to the third plaintiff, and she had elected to have a sterilisation, she would also have known that she would need to make a booking for the procedure.[100]

128.

It must also be pointed out that there was ample opportunity for the nurses to inform the third plaintiff that she would need to make a booking or to make it for her if it was an option chosen by the third plaintiff because the last ante-natal class that she attended was on 3 October 2005 which was during the 39th week of her pregnancy if one has regard to the ante-natal graph and the notes recorded thereon. This was just a week before the third plaintiff went into labour. We submit that the absence of raising this with the third plaintiff – and the lack of an express instruction by a doctor (as opposed to what amounted to a mere recommendation by Dr Krönke), is telling and destructive of establishing informed consent on her part. Had the third plaintiff elected to have a c/s and sterilisation there would, we submit, have been a duty to have assisted her with a booking.[101]

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[100] Rec Vol 9 p 1003 ℓ 10-30

[101] Sonny and Another v Premier Kwazulu-Natal and Another 2010 (1) SA 427 (KZP) at para 69; Exh Rec Vol 1 p 120

129.

Dr Kimberg testified that a booking for caesarean section is usually made 29 weeks into the pregnancy. Dr Krönke, although she initially tried to evade the issue, admitted that the fact that third plaintiff did not make a booking is more consistent with her not wanting or electing to have a caesarean and sterilisation than with her being just negligent.[102]

130.

Notably there is also no record of the third plaintiff receiving family planning education. There is however record of breastfeeding and PMTCT education on two occasions. It is submitted that if family planning education was given, it would have been given. This is another indication that all health personnel assumed that Dr Kronke had counselled the third plaintiff, that she had elected a sterilisation and therefore saw no need to discuss it with her again.[103]

131.

Third plaintiff started having contractions on 12 October 2005. She realised that she was in labour and took the neverapine tablet which was given to her with the instruction that she should take it as soon as she goes into labour.[104]

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[102] Rec Vol 16 p 1841-1843; p 1847 ℓ 20-25

[103] Exh Rec Vol 1 p 115; p 117

[104] Rec Vol 9 p 1003 ℓ 10-30

132.

The third plaintiff testified that she went to the hospital with a taxi where her vital statistics were taken and she was examined. It would appear from the ante-natal care record that the contractions started at 14h00 on 12 October 2005.[105]

133.

The first note that appears in the third plaintiff's maternity record was made at 18h50. As appears from this note the third plaintiff was having severe pain, she had one contraction every 10 minutes for 25 seconds and was 2cm dilated. This was also her testimony. The note also indicates that the third plaintiff was admitted and the plan was to inform the doctor because she was supposed to have an elective caesarean and a sterilisation based on reports in her green passport. Nurse Tjimbundu subsequently explained in her evidence that she was referring to the inscription on the front page and at pages 8 and 14 of Exhibit E.[106]

134.

The third plaintiff testified that she was in extreme pain and although the nurse told her to walk around she could not walk around much because of the pain. As a result she came back and went to lie down on a bed. She testified that she was experiencing continuous and severe pain. She was examined by a white man whom she assumed was the doctor because he

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[105] Exh Rec Vol 1 p 120; Rec Vol 1 p 120; Rec Vol 9 p 1004 ℓ 9-20

was wearing the white clothes worn by doctors. This doctor spoke in English to the nurse. He gave her two tablets the size of panados although she did not know what the tablets were for. Third plaintiff testified that the doctor examined her and left. After the doctor left a nurse returned with a paper in her hand and a stretcher and told her to write, speaking a different language. She then told her in Oshiwambo to write her name ("shanga") and again repeated in Afrikaans "skryf, skryf". Third plaintiff testified that she put her name on the piece of paper whereafter she was told to get onto the stretcher and was wheeled into a white room with big lamps.[107]

135.

The third plaintiff testified that she was only asked to write her name. She did not know why she had to write her name and she did not understand anything contained on the documents. The third plaintiff confirmed that she wrote her name on the two consent forms and that she signed the one but because the writing on the second consent form was faint she did not acknowledge that it was her signature. She did not exclude the possibility that she signed it.[108]

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[106] Exh Rec Vol 2 p 125; Rec Vol 12 p 1352 ℓ 28-30; p 1353 ℓ 4-5

[107] Rec Vol 0 p 1004 ℓ 20 – p 1006

[108] Rec Vol 9 p 1008 ℓ 25 – p 1009; p 1013; Rec Vol 2 p 154-155

136.

Nurse Tjimbundu who testified for the defendant confirmed that she made the inscriptions in the maternity record when the third plaintiff was admitted.[109]

137.

She testified that the next set of inscriptions made in the maternity record was made by a doctor. No time is indicated but the plan was to allow the labour to progress and to keep the membranes in tact for sterilisation at a later stage. Although Nurse Tjimbundu could not recognise the signature it was subsequently confirmed by Dr Sinchinwa and Dr Krönke that the doctor who made the inscription, is Dr Fong who was on duty during that evening. He was not called to give evidence. Dr Krönke testified that Dr Fong actually diverted from a previous treatment plan. He should actually have performed the caesarean section that evening. The treatment plan which she was referring to is her recommendation to third plaintiff on 30 March 2005. This is however clearly a wrong statement to make because she testified that the third plaintiff had not accepted her recommendation at the time and not consented to that in any proper sense at all. There could thus not have been an accepted treatment plan that had to be followed.[110]

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[109] Rec Vol 12 p 1352 ℓ 8-10; Rec Vol 2 p 125

[110] Rec Vol 16 p 1813 ℓ ____; Rec Vol 16 p 1848 ℓ 20-33; Rec Vol 9 p 1353 ℓ 20

138.

From Dr Krönke's evidence it appears that Dr Fong's plan the evening of the 8th was for her to have a normal delivery. The plan changed the next morning and they then also recommended to her to have the sterilisation.[111]

139.

Nurse Tjimbundu also testified that the inscriptions made at 21h50 that evening were made by another nurse. It would also appear from the further notes made that the third plaintiff was examined again at 23h30 and again at 05h35 on 13 October 2005.[112]

140.

Nurse Tjimbundu then testified that the inscriptions made on 13 October 2005 at 08h35 were made during a ward round with the consultant who was Dr Krönke at the time. It would appear from the notes that she was diagnosed as being in prolonged first stage of labour and the plan decided on by the doctors was for her to undergo a caesarean section due to the prolonged first stage and a sterilisation. Dr Sinchinwa testified that Dr Fong made these and also confirmed that it was decided by the doctors that she must have a caesarean and a sterilisation.[113]

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[111] Rec Vol 16 p 1814 ℓ 10-23

[112] Exh Rec Vol 2 p 127; p 126

[113] Exh Rec Vol 2 p 127; Rec Vol 2 p 127; Rec Vol 12 p 1354

141.

The next note which appears on the same page in the maternity record was made by Nurse Tjimbundu according to her own testimony. She testified that her note indicates that the patient was prepared for a caesarean section and a sterilisation and that the patient signed the consent form herself after the doctor explained the operation to her and she agreed.[114]

142.

Nurse Tjimbundu testified that the normal procedure in respect of the signing of consent for an operation is that the doctors will decide upon the required treatment and will explain to the patient before they let the patient sign. In fact, during cross-examination she agreed that the patient would not be involved in deciding the treatment she is to undergo. The doctor should also sign the form.[115]

143.

Dr Sichimwa testified that he signed the consent form for a sterilisation at the space provided for the doctor and that Dr Fong signed as a witness on the generic consent to an operation. He acknowledged that the consent must be signed in the presence of the doctor but that it happens that it is signed by a patient whilst the doctor is not present.[116]

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[114] Exh Rec Vol 2 p 127; Rec Vol 12 p 1354 ℓ 20-29

[115] Rec Vol 12 p 1356 ℓ 16 – p 1357 ℓ 4; Rec Vol 2 p 451

[116] Rec Vol 11 p _____ .

144.

Nurse Tjimbundu also testified that the registered nurse is responsible for obtaining the signed consent from the patient in the presence of a witness who would normally be an enrolled nurse or a student nurse and that she would only do this once the doctor had explained the procedure to the patient in a language which the patient understands otherwise a translator will be called to explain everything to the patient. She testified that if the doctor does not sign the consent form she will make sure that he signs it before the patient goes for the operation. The doctor is supposed to sign at the same time as the patient but at times this does not happen.[117]

145.

On a question during examination in chief as to what would happen when a patient indicates that she wants to have a sterilisation, Nurse Tjimbundu answered that she would then write it on the ante-natal care record and pointed to the inscription on the front page of the third plaintiff's ante-natal care record. She however also indicated that the patient would be referred to a doctor to explain the operation to the patient and that the inscription that the patient wants a sterilisation would sometimes be made inside the ante-natal care record.[118]

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[117] Rec Vol 12 p 1357 ℓ 25 – p 1358 ℓ 30

[118] Rec Vol 12 p 1392 ℓ 10-3____

146.

Nurse Tjimbundu testified that when she admitted the third plaintiff most of her notes were based on information she obtained in the ante-natal care record and that she did not require a detailed discussion with the third plaintiff. An important assumption she made was based on the notes contained on the front page of the ante-natal care record (that the patient wanted a BTL) – that the third plaintiff had already agreed to have a sterilisation. She also acknowledged that she did not have to discuss the issue much with the third plaintiff because it is indicated on the ante-natal care record that she had accepted it. This evidence is consistent with and corroborates third plaintiff's evidence (based upon her recollection) that the nurse only told her to write her name without explaining anything to her.[119]

147.

Nurse Tjimbundu testified that the third plaintiff was seen at 8h45 by the doctors who were going through a ward round with the consultant (Dr Krönke). They discussed her situation amongst each other in English (directly confirming the evidence of the third plaintiff in this regard) whereafter a decision would have been made by the doctors together with the consultant that she should undergo a caesarean section due to her prolonged labour and a sterilisation because she, according to the records on the ante-natal record, appeared to want a sterilisation.[120]

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[119] Rec Vol 12 p 1369 ℓ 14-15; p 1370, p 1374 ℓ 1-30; p 1375 ℓ 19-30

[120] Rec Vol 12 p 1381 ℓ 1-16; p 1382 ℓ 1-10; p 1384 ℓ 19 – p 1385 ℓ 4

148.

Nurse Tjimbundu also accepted that it is quite possible that the doctors did not explain the procedure to the third plaintiff because it was indicated on her ante-natal care record that she wanted the sterilisation although she said that it should still have happened. Once this decision was made a nurse speaking fluent Oshikwanyama would have been called in order to do the translation for the patient. Nurse Tjimbundu could not independently recall whether this indeed happened but said that this is what should happen.[121]

149.

Nurse Tjimbundu then testified that she administered pre-medication for the operation at 8h45 according to the contemporaneous note and that would have happened after the explanation had been provided to the third plaintiff and she had consented to the operation although her signature was only obtained at 09h00.[122]

150.

On Nurse Tjimbundu's version as supported by the contemporaneous records, the third plaintiff was examined by the doctor, a discussion between the doctors and the consultant took place as to the planned treatment whereafter a decision was made, the explanation was given to the patient and the pre-medication was administered – all within 10 minutes from 8h35 to 8h45. This, we submit, is highly improbable especially in light of the fact

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[121] Rec Vol 12 p 1364 ℓ 25-30; Rec Vol 12 p 1386 ℓ 1-15

that the third plaintiff is clearly unsophisticated in the context of Western medicine and that it clearly takes her long to understand when things are explained to her. This was roundly demonstrated by her evidence. The court was able to observe this.[123]

151.

It is however not quite clear from the evidence of Nurse Tjimbundu and Dr Sichimwa as to who gave the explanation to the third plaintiff. Nurse Tjimbundu testified that it must have been Dr Sichimwa because he signed the declaration at the bottom of the consent form for a sterilisation.

152.

Dr Sichimwa testified that he must have explained the sterilisation procedure and that Dr Fong must have explained the caesarean because he (Dr Fong) signed the generic consent form. In the context of the times contemporaneously recorded this is highly improbable.[124]

153.

Dr Sichimwa's evidence in this regard is confused because he also testified that normally the one doctor would go to theatre whilst the other one gives the patient the explanation. They would both have stayed behind with the patient on his improbable *ex post facto* version. It is not clear why the one

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[122] Rec Vol 12 p 1390 ℓ 18-31

[123] Rec Vol 12 p 1391 ℓ 1-20

[124] Rec Vol 11 p 1288 ℓ 10-25

would explain the one procedure and the other doctor the second procedure.[125]

154.

Further on in his evidence Dr Sichimwa testified that it would have taken him 10 minutes to explain both procedures because he assumed from the notes made by Dr Krönke on 30 March 2005 that the sterilisation procedure was canvassed with and explained to her on that day. This turns out to be an incorrect assumption based on Dr Krönke's evidence.[126]

155.

The notes in the maternity record are also not of any assistance to the defendant because they do not say which doctor explained the procedures or what, if anything, was ever stated by them.[127]

156.

Significantly Nurse Tjimbundu also testified that there have been certain changes to the procedures regarding the obtaining of consent for operations and specifically the signing of the consent form since these cases have been made. She testified that the doctors now attend to the explanation and sign the form with the patient before they do the operation. She also testified that they make proper notes to the effect that they explained the procedure to the

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[125] Rec Vol 11 p 1287 ℓ 18-23

[126] Rec Vol 11 p 1302 ℓ 28-32; p 1303 ℓ 10-20

[127] Rec Vol 2 p 127

patient. Nurses no longer sign consent forms as witnesses although they still secure the signature of the patient in the presence of the doctor.[128]

157.

Nurse Tjimbundu also agreed that the family planning provided during group sessions at ante-natal care classes would not constitute counselling in any proper sense and that individual counselling is still required. Nurse Tjimbundu also testified that they do not go into detail in the discussions as to what different methods are available. They only show the patients what different methods are available. If a patient indicates during an ante-natal care class that she wants a sterilisation she would be referred to a doctor for proper counselling. This was also confirmed by Dr Krönke.[129]

158.

Third plaintiff testified that after she signed the forms she was taken to the theatre. All of this including the signing of the form was done in a hurry. This is also the most probable scenario. She had by then already been in labour since 14h00 the previous day which, on the evidence of all the health practitioners, places the baby at risk.[130]

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[128] Rec Vol 12 p 1406 ℓ 20 – p 1407 ℓ 15

[129] Rec Vol 16 p 1826 ℓ 17-31; Rec Vol 12 p 1407 ℓ 20-32; p 1409 ℓ 30 – p 1410 ℓ 1

[130] Rec Vol 9 p 1015

159.

Third plaintiff testified that there were two men in the room, the one massaging her stomach and the other one her lap. She felt an injection and after a while she had no sensation in the bottom part of her body. She at the time thought that she was given the injection to relieve her of the pain, consistent with her version that the procedures including the epidural anaesthetic had not been explained to her in a language she could understand.[131]

160.

It is obvious from third plaintiff's evidence that she did not know what was happening to her. After some time the nurse showed her her baby. She only realised a while later that she had been operated on because of the pain she experienced after a while. Up to that point third plaintiff had contemplated a normal delivery. She only found out subsequently that she had also been sterilised when she heard two nurses talking about it in the ward.[132]

161.

We submit that it follows that the sterilisation procedure performed upon the third plaintiff was done on the basis of an assumption on the part of the health professionals that the third plaintiff wanted to undergo that procedure, based upon inscriptions in her medical records. When these inscriptions are

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[131] Rec Vol 9 p 1016-1017

[132] Rec Vol 2 p 34-35

examined and the evidence was given concerning them, it is plain that not one of them at any stage whatsoever amounted to informed consent – or consent in any form whatsoever. In the case of Dr Krönke, it merely constituted a recommendation – understandably made by her in the context of a request for termination of pregnancy of a woman who had already reached 40 years of age, who had previously had several children and difficulties with regard to recent deliveries and her HIV status. Dr Ithete's evidence does not, we submit, assist the defendant at all. Nor does the evidence of the nursing staff.

162.

Indeed, we submit in the case of the third plaintiff that the defendant has clearly not established informed consent and that the sterilisation procedure was performed on her based upon assumptions on the part of medical personnel that she had previously requested it and understood the nature and consequences of the procedure – none of which was ever established in evidence and indeed contrary to the third plaintiff's unequivocal – and generally unequivocal evidence generally not contradicted in any material way by contemporaneous notes or the evidence given by the health professionals in question. The court was able to observe her difficulty in following the court proceedings and questions put to her. The version of the defendant is furthermore highly improbable with regard to any explanation being given and informed consent being obtained prior to the operation with reference to the time span and would have been required to have explained the procedure to the third plaintiff and for her to properly appreciate it and its

consequences in the short time span possible reflected in the contemporaneous notes.

163.

We submit that the third plaintiff's claim on the merits has thus been established.

N Bassingthwaighte

Counsel for the Plaintiffs

NB/mb/1006

CASE NO: SA 49/2012

IN THE SUPREME COURT OF NAMIBIA

In the matter between:

GOVERNMENT OF THE REPUBLIC OF NAMIBIA	**APPELLANT**
and	
LM	**1st RESPONDENT**
MI	**2nd RESPONDENT**
NH	**3rd RESPONDENT**

LIST OF AUTHORITIES

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1. Castell v De Greef 1994 (4) SA 408 (C) at 420H; 425H-426G; 426I-427B

2. Rogers v Whitaker (1993) 67 ALJR 47

3. C v Minister of Correctional Services 1996 (4) SA 292 (T) at 300G-H

4. Christian Lawyers Association v Minister of Health 2005 (1) SA 509 (T) at 515E-516C

5. Louwrens v Oldwage 2006 (2) SA 161 (SCA)

6. Broude v McIntosh and Others 1998 (3) SA 60 (SCA) at 69E

7. Sonny and Another v Premier Kwazulu-Natal and Another 2010 (1) SA 427 (KZP) at para 69

SUPREME COURT OF NAMIBIA

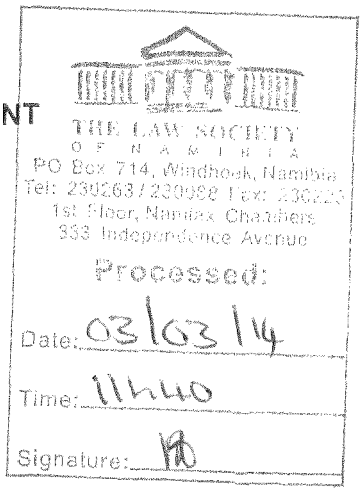
AND TO: GOVERNMENT ATTORNEY

LEGAL PRACTITIONERS FOR APPELLANT

2ND FLOOR, SANLAM BUILDING

INDEPENDENCE AVENUE

WINDHOEK



NB/ct/mb/1005

CASE NO: SA 49/2012

IN THE SUPREME COURT OF NAMIBIA

In the matter between:

GOVERNMENT OF THE REPUBLIC OF NAMIBIA	**APPELLANT**
and	
LM	**1st RESPONDENT**
MI	**2nd RESPONDENT**
NH	**3rd RESPONDENT**

RESPONDENTS' HEADS OF ARGUMENT

1.

The appellant appeals against the court's finding that it failed to discharge its onus (in respect of all three respondents) to prove that the three respondents had given their informed consent in respect of a sterilization procedure performed on them at State hospitals. The parties are referred as in the High Court.

INTRODUCTION

2.

Three different claims were instituted by the three plaintiffs. Their claims were consolidated during July 2009 by reason of the similarities between the three cases. Each one of the cases was however decided on their own merits. Evidence of some of the witnesses however overlapped and applied to all three cases. This related mainly to the standards applicable in obtaining informed consent and the procedures and policies applicable to medical and health practitioners in general and specifically within State hospitals.

3.

It was also agreed between the parties that the issue of quantum would stand over for adjudication at a later stage.

4.

Each one of the plaintiffs' principal claim for damages arises from what they in their respective pleadings allege to be an unlawful sterilisation performed upon them without their consent by medical practitioners in the employ of the State at State hospitals, alternatively on the grounds of a breach of the duty of care that these medical practitioners owed to each of the plaintiffs. This claim was pleaded by each of the plaintiffs in similar terms. The plaintiffs claim violations and infringements of their common law rights to personality in the respects set out in paragraph 6 of each of their particulars and in the

alternative a violation and infringement of their rights guaranteed and protected under the Namibian Constitution and most particularly the right to human dignity protected in Article 8 as well as those rights protected in Articles 7 and 14 of the Constitution.

5.

In a second claim, each of the plaintiffs allege that the sterilisations were done as part of a wrongful and unlawful practice of discrimination against them based on their HIV status and that it thus amounts to a breach of their basic rights guaranteed to them under the Constitution of the Republic of Namibia. In view of its finding in relation to the principal claim the court did not deal with the alternative claim. The second claim of the respondents failed as the court found that there is no credible and convincing evidence to support the second claim.

6.

It is common cause that first plaintiff signed a general consent form provided by the State hospitals for surgical procedures. The second and third plaintiffs also signed this consent form but in addition signed a second form which specifically refers to and relates to a sterilisation procedure.

7.

It is common cause that all three plaintiffs underwent a sterilisation procedure which has rendered them unable to bear children. The defence of the appellant is *volenti non fit iniuria* based on the fact that the respondents

each signed a written consent to the operations. It was however accepted by the appellant's own witnesses that what is required is informed consent and not just written consent.

8.

The issue to be decided in each case was therefore whether the defendant obtained the plaintiffs' informed consent for the sterilisation procedure. It is submitted, with respect, that this entails is not as simple as the defendants put it in its heads of argument. The question is not merely whether the plaintiffs were informed that sterility is a risk or consequence of a sterilization procedure. The question before Hoff J, and which he clearly appreciated was whether they had been provided with adequate information in order to make an informed decision and were in fact able to do so.

9.

The information they required in this instance is not merely that sterility is a consequence of a sterilization procedure. This Hoff J also stated in his judgment what this information is contrary to the defendants' assertion in its heads of argument. He stated that a patient must also at the time when the sterilization is considered as an option be informed of the alternatives available and their advantages and disadvantages.[1]

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[1] Rec Vol 17 p 2055 para 70

10.

The onus to prove whether there was informed consent vested on the defendant, even if it is found that the evidentiary burden shifted to the plaintiffs based on their admission that they signed consent forms.

INFORMED CONSENT

11.

It is accepted by all parties that what is required for purposes of a surgical procedure is informed consent and not merely written consent. Recent authority has also established that informed consent is what is required in accordance with the common law. In a leading judgment in this regard, a full bench, per Ackermann J (as he then was), in Castell v De Greef[2], after a detailed and thorough comparative survey, firstly placed this doctrine within its common law context, by stating at 420H:

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

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[2] 1994 (4) SA 408 (C)

It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination."

12.

In expanding upon the doctrine of informed consent after referring to a leading Australian case of Rogers v Whitaker[3], the court concluded at 425H–426G:

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

(a) the consenting party 'must have had knowledge and been aware of the nature and extent of the harm or risk';

(b) the consenting party 'must have appreciated and understood the nature and extent of the harm or risk';

(c) the consenting party 'must have consented to the harm or assumed the risk';

(d) the consent 'must be comprehensive, that is extend to the entire transaction, inclusive of its consequences'.

(See Van Oosten (op cit at 13-25 and the authorities there cited).)

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[3] (1993) 67 ALJR 47

Similarly the criticism in Rogers v Whitaker of the expression 'informed consent' was on the basis that '. . . consent is relevant to actions framed in trespass, not in negligence. Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass. . . .'

As indicated above, the position in South African law is quite different and the expression 'informed consent' is an appropriate one.

Of particular importance is the conclusion of the Court in Rogers v Whitaker at 52 that:

> 'The law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege.'

This test bears a very close resemblance to the blending of the 'reasonable patient' minimum with the individual patient 'additional needs test' proposed by Giesen and discussed above.

In my view we ought, in South Africa, to adopt the above formulation laid down in Rogers v Whitaker, suitably adapted to the needs of South African

jurisprudence. It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe. The majority view in Sidaway must be regarded as out of harmony with medical malpractice jurisprudence in other common law countries.

I therefore conclude that, in our law, for a patient's consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

(a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or

(b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

And further[4]:

" 'The ultimate question', as King CJ stated in F v R, is 'whether (the defendant's conduct) conforms to the standard of reasonable care demanded by the law. That is a question for the Court and the duty of

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[4] At 426I–427B

deciding it cannot be delegated to any profession or group in the community.'

As King CJ considered in F v R at 192 (a passage approved in Rogers v Whitaker at 51):

> 'What a careful and responsible doctor would disclose depends upon the circumstances. The relevant circumstances include the nature of the matter to be disclosed, the nature of the treatment, the desire of the patient for information, the temperament and health of the patient'."

See also: C v Minister of Correctional Services[5]:

> "Consent is a defence to many acts which would otherwise be a delict. An obvious example is consent to surgery. In recent years the concept that consent must be 'informed consent' has found favour with our Courts: see Castell v De Greef 1994 (4) SA 408 (C) at 420I-421D and 425C-426G. In regard to surgery, informed consent postulates full knowledge of the risks involved and, after being made aware thereof by H the surgeon, the patient is then entitled to exercise his 'fundamental right to self-determination' (at 420I)." [6]

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[5] 1996 (4) SA 292 (T) at 300G-H

[6] And more recently: Christian Lawyers Association v Minister of Health 2005 (1) SA 509 (T) at 515E-516C where the requirements of knowledge, appreciation and consent for the purpose of informed consent are more fully explained.

13.

The doctrine of informed consent in the Castell case was applied and cited with approval by the (South African) Supreme Court of Appeal in Louwrens v Oldwage[7]. This after that court had in Broude v McIntosh and Others[8] found it unnecessary to pronounce upon the correctness of Castell.

14.

As we have pointed out, the concept of informed consent was accepted as being required in the circumstances of each of the plaintiffs' cases by the defendant's medical witnesses.[9]

15.

The defendant's medical personnel accepted that it is a surgeon's legal duty to obtain informed consent from a patient although a registered nurse may be requested to procure the patient's signature on the consent form. This is also in accordance with the ethical standards governing health professionals, as set out in the Guidelines for them issued by their professional councils. If the nurse however takes it upon herself to explain the operation to the patient such a nurse can also be held liable for negligence.[10]

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[7] 2006 (2) SA 161 (SCA)

[8] 1998 (3) SA 60 (SCA) at 69E

[9] Rec Vol 14 p 1615 ℓ 5-8

[10] Rec Vol 10 p 1172 l 5-15; Rec Vol 15 p 1677 ℓ 19-2; p 1723 ℓ _____; Exh Rec Vol 2 p 195-196

16.

Dr Kimberg, an experienced gynaecologist and obstetrician, was called as an expert witness by the plaintiffs. He testified, and his evidence was not disputed in this regard, that a patient who is to undergo a sterilisation procedure must receive adequate counselling before such a decision is to be taken. The accepted ethical standards (also confirmed in the defendant's policies) that apply in respect of such counselling in the context of sterilisation require that the following issues be discussed with the patient:

16.1. The permanence of the procedure;

16.2. The nature of the procedure and what the patient will experience during and after the procedure;

16.3. The reasons why the couple wants the procedure and the effect of a possible change in circumstances on their decision;

16.4. Possible risks, failure rates and side effects;

16.5. The alternative methods of contraception available to the patient;

16.6. That the patient is entitled to withhold her consent even if the doctor might consider it in her best interest to do so.[11]

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[11] Rec Vol 10 p 1158 ℓ 19-31; p 1159 ℓ 1-31; p 1160 ℓ 10-20; Exh Rec Vol 2 p 190 (Exhibit H)

17.

Dr Kimberg testified that a patient's decision to be sterilised should not be taken during labour. It should rather be taken during the pregnancy and preferably, although not legally required, in the presence of the patient's partner. He testified that counselling should be done in an unhurried fashion and without any pressure of circumstances or without any undue influence from the doctor, in a language which is clearly understood by the patient. This was also in accordance with the literature provided by the defendant as applying to midwifery.[12]

18.

This was also accepted by the defendant's witnesses in varying degrees and especially by Dr Krönke, also a gynaecologist and obstetrician.[13]

19.

The circumstances must be such that the patient is able to understand the information and weigh that information as part of the process of making a decision. The patient should also be able to properly communicate that decision. These standards were accepted by the defendant's witnesses to be the applicable standard in their profession.[14]

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[12] Rec Vol 10 p 1163 ℓ 10-20; p 1170 ℓ 10; Exh Rec Vol 2 p 190 and 192 (Exhibit H)

[13] Rec Vol 16 p 1819 ℓ 20 – p 1820 ℓ 10; ℓ 20-32

[14] Exhibit H p 36

20.

Dr Kimberg also testified that sterilisation is contra-indicated in respect of patients under the age of 30 years because the statistics have shown that the highest incidence of regret after sterilisation is found to be amongst women under the age of 30. He added that it would be irresponsible of a doctor to even offer a sterilisation to such a patient at the height of labour. Even if the patient was to ask for the procedure she should rather be advised to return after six weeks after having considered the decision properly. Dr Mavetera, also a gynaecologist, stated his qualified acceptance of this whilst Dr Krönke accepted this.[15]

21.

Dr Kimberg also emphasised the importance of record keeping in the counselling process and in respect of consent. As he put it, no notes no case. All the witnesses for defendant accepted that it is important to keep an adequate record of what the patient was told during the counselling process about the history, diagnosis and proposed treatment. Proper records should also be kept of the alternatives put to the patient, the consequences and risks of the proposed treatment and the patient's decision. He stressed that proper and complete recordkeeping is even more important within the context of a hospital set up because patients see different doctors all the time. This also occurred in respect of all three plaintiffs.[16]

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[15] Exhibit H p 36; Rec Vol 10 p 1170 ℓ 19-24; p 1171 ℓ 1-21

22.

Dr Kimberg's opinion is also confirmed in the literature discovered by the defendant. This literature is available to medical personnel during their studies and at the institutions where they are employed.[17]

23.

It is clear from all the records by the hospitals in respect of the three plaintiffs that the records and notes made by the health professionals were entirely inadequate and incomplete and did not comply with the required ethical standards. This fact was also acknowledged by Dr Krönke who in her evidence commented on the records of all three patients as being inadequate. Other witnesses for the defendant also in more limited fashion and in varying degrees accepted the inadequacy of the recordkeeping in the 3 cases.

24.

It is against these standards that the conduct of the defendant's employees must be measured when considering whether the defendant has discharged the onus of establishing informed consent. This is also the standard which was, correctly, applied by Hoff J in his judgment of the matter.

25.

We turn now to the evidence in respect of each of the plaintiffs.

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[16] Rec Vol 10 p 1161 ℓ 1-25

First Plaintiff

26.

It is common cause that the first plaintiff gave birth by way of an emergency caesarean section on 13 June 2005 because she was diagnosed with a condition known as cephalic pelvic disproportion (CPD) whilst in labour and at a time when her membrane had already ruptured. In layperson's language, CPD means that the baby's head is too big to pass through the pelvis without trauma. A sterilisation procedure was performed at the same time on the first plaintiff. It is first plaintiff's case that she did not consent to the sterilisation procedure and furthermore that it was performed on her due to her HIV status.

27.

The defendant claimed that the sterilisation procedure was performed on the first plaintiff at her own request after both procedures and their consequences were explained to her and her written consent was obtained. In fact it was put to her under cross-examination that she requested the procedure in Ohsiwambo and that she used the words "ondahala opuputwa". It was put to her that this would be the evidence of both Dr Mavetera and Nurse Angula.[18]

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[17] Rec Vol 10 p 1167 ℓ 21 – p 1168 ℓ 2

[18] Rec Vol 7 p 820 ℓ 4-11

28.

This implies that either there is a record of the request or the doctor or nurse had an independent recollection of the discussion they had with first plaintiff. Significantly neither Dr Mavetera nor Nurse Angula testified that the request was made by using the specific words. Both confirmed that they do not have an independent recollection of the first plaintiff and that the only reason why they say she requested the procedure is because there is a standing procedure to only perform a sterilization if the patient requests it.[19]

29.

The defence as far as the first defendant is concerned is further that she received adequate counselling during the ante natal classes that she attended (4 classes) where she would have been informed of the methods of contraceptives available as an alternative to sterilisation and where the nature and consequences of the procedure would also have been explained to her.

30.

We submit that based on the evidence, the court was correct in its finding regarding the first plaintiff. It was common cause that the "plan" in respect of first plaintiff was that she would deliver naturally. This was her evidence and confirmed by Dr Mavetera. The plan only changed when she was diagnosed with CPD on 13 June 2005. We submit that first plaintiff had no intention to

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[19] Record Vol 14 p 1590 ℓ 19-23; p 1598 ℓ 20-25

have a sterilisation. Had she formed such an intention a booking would have been made for the procedure and the plan for delivery would have been a caesarean. The first plaintiff's evidence as far as this is concerned is also borne out by the medical records.[20]

31.

There was no contemporaneous record of any request for, or any expressed intention on first plaintiff's part to have a sterilisation, in any of her medical records. Had she requested such an invasive procedure, it should have been noted – even obliquely or in summary form. The defendant's witnesses also confirmed this fact when they testified. This corroborates her evidence.[21]

32.

An important finding of fact which Hoff J made is the fact that both Dr Mavetera and Nurse Angula assumed that first plaintiff was counselled on sterilization during her ante natal classes. Dr Mavetera also assumed that the first plaintiff would have made the decision before she came for delivery. Based on this assumption, they further assumed that she knew and understood what the consequences are of the procedure and that there are alternatives. As a result, they testified that their explanation was limited to informing her that the procedure is permanent and that she will not be able to have children. In fact Dr Mavetera stated that they do not "give a lecture". He

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[20] Exh Rec Vol 1 p 9, 14-15; Rec Vol ___ p 803 ℓ 3-4; Vol14 p1643 ℓ 20-24

further testified that they would normally tell them that there are other options but in this case he cannot recall what she was told but what he can safely say is that they stress to them that this decision is permanent and that they will not have babies anymore. His evidence was that they would not deal with the alternatives in full, only in summary because he assumed that they would have dealt with that in the ante – natal classes.[22]

33.

The first plaintiff testified that they were provided family planning information at the ante natal classes and that they were advised to get family planning after the baby is born to avoid another pregnancy whilst the baby is still young. This she said was done in a group session. She further testified that she did not get any counselling on sterilization or that it is an alternative type of contraceptive. When it was put to her under cross-examination that she knew that there are other alternatives to sterilization before she went for the operation, the first plaintiff's response was "My lord the operation, there was no question of family planning as I was pregnant already." This clearly shows that the first plaintiff was not even contemplating a sterilisation or any other form of contraceptive at the time. She in fact did not know what the term sterilization means until it was explained to her long after the procedure was performed on her. She did however admit that she knew that when your uterus is removed, you will not be able to have children. The plaintiff further

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[21] Rec Vol 15 p 1712 ℓ 8-13; Vol 14 p 1639 ℓ 10-26

[22] Rec Vol 14 p1591 ℓ 20-30; p 1593 ℓ 30-32; p 1616-1618; p 1636 ℓ 10-20

testified that neither Dr Mavetera nor Nurse Angula gave her any explanation about sterilization.[23]

34.

The first plaintiff's evidence is once again borne out by the medical records. There is no record of counselling on sterilisation during ante natal classes in her health passport. There is however record of pre-test, post –test counselling and HAART counselling done on different days. This, one must accept was a note made after individual counselling was done. If individual counselling on sterilisation was done and the first plaintiff actually expressed a desire to have sterilisation, it would surely have been recorded and a booking would have been made for the procedure. Dr Mavetera testified that the decision to have a sterilisation should have been made during ante natal classes or before coming for the delivery. The absence of a record of such a decision should surely have made him realise that the first plaintiff did not make such a decision before she came for her delivery.[24]

35.

Neither Dr Mavetera nor Nurse Angula made a note on the medical records that they gave any explanation to the first plaintiff regarding sterilisation. They both acknowledged that they should have made a record that the

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[23] Rec Vol p810 ℓ25-26; 813 ℓ16-19; p 817 ℓ15-20; p 833 ℓ1-5; p 844 ℓ10-33-845 ℓ1-30

[24] Exh Rec Vol 1 p5, 7

explanation was done. The excuse for this is that because of their workload they do not have time to write everything down.[25]

36.

We submit that the group ante-natal classes would not be sufficient or adequate for purposes of obtaining informed consent from a patient for a sterilisation in the future. Although some patients may conceivably after such sessions be able to make an informed decision to be sterilised, it remains a doctor's duty to satisfy himself or herself that the patient understands fully and that she can make such a decision and thus to secure informed consent. This was also the evidence of Dr Krönke. It must therefore be accepted that in the case of first plaintiff, the decision to perform a sterilisation was thus taken at the height of labour. In fact she had by then been in labour for 14 hours, and before that had over the preceding days sought treatment for pain which had preceded her labour. Even if the defendant's version that she requested the sterilisation, such a request should have been refused and she should have been advised to return after 6 weeks. The evidence shows that the first plaintiff was not in a condition to make such a decision nor was there sufficient time for Dr Mavetera and Nurse Angula to make sure that the first plaintiff's consent is informed.

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[25] Exh Rec Vol 1 p15; Rec Vol 14 p 1594 ℓ5-10; p 1635 ℓ10-20; p 1636 ℓ9-11; Vol 15 p 1711-1712; p 1717 ℓ19-21

37.

At the time of the operation, the first plaintiff was only 26 years old. She was also then unmarried. She only had one child. Her second child was stillborn. These facts were known to Dr Mavetera at the time. He testified that these are factors are considered when a patient request a sterilisation. Despite this knowledge Dr Mavetera considered a "request" for sterilisation to be reasonable because she already had one child.[26]

38.

The first plaintiff's ordeal started on 9 June 2005 when she started discharging blood when she went for the ante natal care ("anc") at the clinic in Ongwediva. Considering that she had already had a stillbirth, this must have caused her some anxiety. She was then taken to Oshakati State Hospital. Upon examination at the hospital it was found that she was dilated with the tip of the finger although she was then not yet having any contractions.[27]

39.

The first plaintiff was advised to walk around and come back after 4 hours. When she came back, the nurses told her to go and come back the next day if contractions were to start or if her membrane were to rupture.[28]

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[26] Exh Rec Vol 1 p 1

[27] Exh Rec Vol 1 p 8; Rec Vol 7 p 795 ℓ 20-25

[28] Exh Rec Vol 1 p 9

40.

The first plaintiff returned to the hospital on 10 June 2005 because she started experiencing contractions although it was not so painful. According to the notes in the ante natal care record, first plaintiff had arrived at the hospital at 20h23. She was having 2 contractions of 25 seconds every 10 minutes and was 2cm dilated. The first plaintiff remained at the hospital at an area which she described as a waiting area where pregnant women are checked. Nurse Angula testified about a preparation room which is the room where patients go when they arrive at the hospital. It is assumed that the first plaintiff referred to the same place. (See also reference in ante natal care record). She was once again advised to walk around and wait for stronger contractions.[29]

41.

The first plaintiff continued to have contractions on the 11 June 2005 but they were still not strong enough and she had only dilated 2cm. She was advised to continue walking around and wait for stronger contractions.[30]

42.

On 12 June 2005, the contractions became severe and the first plaintiff testified that it was more painful. According to the notes in the first plaintiff's ante natal care record she arrived at hospital around 14h00. This time a doctor was called to see her because she also had a yellowish discharge.

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[29] Rec Vol 1 p 44; Exh Rec Vol 1 p 9

[30] Rec p 45; Exh Rec Vol 1 p 9

According to Dr Mavetera, the doctor who saw first plaintiff is Dr Gideon who also performed the operation. The first plaintiff was admitted and moved to the labour ward/delivery room at 19h00. She was again advised to walk around in the ward and wait for stronger contractions.[31]

43.

The first plaintiff testified that the pain became more severe on 13 June 2005 to the extent that she was unable to walk around. She testified that a doctor came to see her around 12h00 according to her recollection. The only doctor who saw first plaintiff on 13 June 2005 before the operation according to the maternity record, is Dr Mavetera. The evidence of the first plaintiff up to this point was undisputed and is also confirmed and corroborated by the notes in her ante natal care record and her maternity record.[32]

44.

Nurse Angula testified that she saw first plaintiff around 13h00 on 13 June 2005. She saw on the maternity record that her membrane had ruptured already at 08h30. Because the first plaintiff is HIV positive, she could not be left to continue in labour for more than 4 hours with a ruptured membrane as this could be dangerous for the baby as she could then be more easily be infected with the virus. Nurse Angula testified that she decided to call Dr Mavetera. He, on Nurse Angula's version, must have arrived sometime after 13h00. This must be so because Nurse Angula first

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[31] Exh Rec Vol 1 p 14

[32] Rec Vol 1 p 802 ℓ 1-5; Rec Vol 1 p 9, 15

went through the first plaintiff's records before she called the doctor. The exact time is unknown because Dr Mavetera inexplicably and unfortunately did not record the time in his note, although he admitted that he should have recorded it. This is also the required standard regarding recording. It is compulsory for a health professional to record the time, date and place of each consultation.[33]

45.

Dr Mavetera himself must either have first gone through the records, or ask first plaintiff some questions (which would have had to be translated) then done a thorough examination on the first plaintiff. After examining her he told her that she could not give birth naturally and required a caesarean section (c/s). Plaintiff testified that the reason given to her, or how she understood it at the time, is that she was too exhausted and could not deliver naturally. She said the doctor spoke to her in English and a nursing student translated to her. Dr Mavetera confirmed that he would have spoken in English but said that Nurse Angula would have interpreted.[34]

46.

Dr Mavetera and Nurse Angula, although not disputing that plaintiff must have been tired at the time, both testified that she was informed that she was diagnosed with CPD (cephalic pelvic disorder) and that it was the reason why a caesarean had to be performed. They both testified that although

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[33] Rec Vol 14 p 1672 ℓ 27-33; Rec Vol 2 p 176-177

[34] Rec Vol 7 p 803

there was a nursing student in the ward, Nurse Angula would have done the translation because a nursing student is not allowed / authorised to do translations according to certain rules or standing orders. This aspect, regarding standing orders or rules about translations was not put to first plaintiff in her cross-examination. This is significant because no such standing orders or rules were discovered by the defendant. This despite notices to discover and a Rule 35(3) notice having been given, which would have required such discovery. After the explanation Nurse Angula prepared the first plaintiff for surgery which involved giving her medication, (given at 13h15) measure her blood pressure and recording it. Then she must have left to collect the consent form and have it signed. The form was also signed at 13h20. All of this was done between 13h00 and 13h20 when Nurse Angula recorded that she has prepared the patient for surgery. There must also have been some urgency because the baby was at risk.[35]

47.

The first plaintiff testified that she was tired and in severe pain when the doctor came to see her. Although Dr Mavetera and Nurse Angula tried to play down the severity of the pain that first plaintiff must have been experiencing based on the contractions, Dr Mavetera accepted that she must have been tired and that different people have different thresholds for pain. The first plaintiff had been in labour for about 14 hours and there were complications which prompted the plan to be changed from a natural birth to

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[35] Rec Vol 15 p 1722 *l*10-20

a caesarean. Apart from being tired and in pain, the first plaintiff at the time when the so-called explanation was being given to her must also have been experiencing serious anxiety. It is must thus be accepted that there was not enough time to provide adequate counselling.[36]

48.

The fact that the first plaintiff signed a consent form does not assist the defendant's case. The plaintiff testified that she did not know what she was signing. The consent form makes no reference to sterilisation. It was a general form used for all operations. It simply said "C/S due to CPD + BTL". The plaintiff testified that she did not understand the acronyms "C/S due to CPD and BTL" which appeared on the form. Both Dr Mavetera and Nurse Angula accepted that plaintiff could not have understood these acronyms and that they should not have been used on the consent form. In fact, it was put to Dr Mavetera that Dr Kimberg testified that the use of acronyms on a consent form is undesirable and he agreed with this view. The first plaintiff testified that she signed the document thinking it may be for purposes of the delivery of the baby because that is why she was at hospital. She did not think the sterilisation (raised by the nurse) would be done immediately. Significantly, Dr Mavetera stated that after the plaintiffs have instituted their actions against the defendant, the Oshakati State hospital had for the first time introduced the second form in respect of sterilisation – the form is specific to that procedure. He also conceded that the generic form and

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[36] Rec Vol 7 p811 ℓ32 – p 812 ℓ1-2; Vol 14 p1606 ℓ10-25