



AN ANALYSIS OF INFORMED CONSENT AND CLINICAL ASPECTS REGARDING MENTAL CAPACITY IN CONTEXT OF THE MENTAL HEALTH CARE ACT 17 OF 2002

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Magister Legum

by

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Declaration of originality

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L ZWART

In the depths of winter, I finally learned that within me there lay an invincible summer.¹

¹ Camus A 'Return to Tipasa' in *Lyrical and critical essays* (ed Thody PMW) (1968) 162 at 169.

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Abstract

This study aims to establish a coherent framework for informed consent by mentally ill persons in South Africa, with specific focus on the role and impact of the Mental Health Care Act 17 of 2002. The analysis is done from a constitutional-, legislative-, common law- and ethics perspective. Selected clinical aspects pertaining to informed consent by mentally ill persons are explored with reference to the different categories of mental health care users provided for in terms of the Mental Health Care Act. It is found that although the Mental Health Care Act has made considerable progress in terms of promoting the basic human- and health rights of the mentally ill, discrepancies and deficiencies are still present in the Act which may result in unnecessary confusion and prejudice to the rights of mental health care users, hence undermining the objectives of the Act itself. An attempt is made to address the current shortcomings and discrepancies within the mental health care system by means of suggested amendments to the Mental Health Care Act.

Key terms: fundamental rights, international standards of mental health care law, biomedical ethics, self-determination, autonomy, medical paternalism, consent to harm, *volenti non fit iniuria*, bodily and psychological integrity, informed consent, duty of disclosure, Mental Health Care Act 17 of 2002, mental capacity, mental illness, assisted mental health care user, involuntary mental health care user, clinical psychiatric assessment, psychiatric diagnosis and classification, DSM-5, ICD-10.

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Chapter 1

Introduction

1.1 Introduction

The Mental Health Care Act (the “MHCA”)¹ has been a major step toward changing the face of mental health care in South Africa to better conform to constitutional- and international human rights standards.² The Act’s provisions relating to informed consent by mentally ill persons is no exception. There are, however, a number of technicalities in the MHCA which still create uncertainty and lead to inconsistencies in the Act’s implementation, which may be undermining the underlying aims of the Act itself. It is these issues and inconsistencies which form the basis of the present study.

This chapter will provide an overview of the remainder of the study. The problem statement and research aims will be briefly explored, following which an explanation will be given regarding the approach and methodology which will be followed in conducting the study. A short summary of the division of the chapters will be included. For purposes of clarification and ease of reference, brief explanations and definitions will be provided for some of the concepts which are used throughout the remainder of the dissertation.

¹ 17 of 2002, as amended (the “MHCA”).

² Freeman M ‘New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health’ (2002) *South African Psychiatry Review* 4 at 4-5; Zabow T ‘The Mental Health Care Act (Act 17 of 2002)’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 58 at 58.

1.2 Research aims and research questions

1.2.1 Aims and significance of the study

The chief aim of the study is to identify and attempt to address selected issues relating to informed consent in the context of mental health care law, with specific reference to the MHCA.

Throughout, the discussion integrates other sources of law and ethics which have informed and continue to inform the mental health care system and laws governing informed consent. The MHCA is continually viewed against the backdrop of the South African constitution (the “CRSA”),³ international mental health law guidelines, common law and legislation governing informed consent in general, and biomedical ethics.

The study seeks to address some of the discrepancies and uncertainties in the existing framework by suggesting certain amendments to the current MHCA. The proposed amendments to the MHCA should serve to address the existing legislative inconsistencies and uncertainties in a manner congruent with international human rights law, the provisions of the CRSA, the underlying aims of the MHCA itself, and biomedical ethics in general. The suggested amendments will be formulated to harmonise with the existing constitutional-, legislative-, common law- and ethical frameworks of consent and mental health care.

1.2.2 Research questions and scope of the research topic

For various reasons informed consent by psychiatric patients can be a complex and problematic field, and a breeding ground for many legal- and ethical challenges.

³ The Constitution of the Republic of South Africa, 1996 (the “CRSA”).

Some of the questions which will be used as a means to guide and structure the research include:

- What are the fundamental human rights underlying informed consent in the context of mental health care, and what is the relevance of the constitution?
- What are the basic principles of informed consent and what is their relevance to the psychiatric context?
- Except for what is provided in terms of the MHCA, what other justifications exist for the provision of mental health services in the event of a psychiatric emergency?
- How does the MHCA regulate and impact upon informed consent by mentally ill persons? More specifically, what are the procedures for mental health treatment-provision in the event of mentally ill persons who are able to give informed consent to treatment, as opposed to those who are unable to give informed consent?
- How do the clinical concepts, interpretations and evaluations pertaining to mental illness, capacity and dangerousness cohere to the provisions of chapter V of the MHCA?

Owing to time constraints and limited available space, the research topic will not include the entirety of the MHCA's provisions, nor even all provisions relevant to informed consent. The present study specifically does not extend to:

- Legal comparison. The study does not contain any significant degree of legal comparison.

- Informed consent by minors. The present study specifically excludes discussions of informed consent by mentally ill minors and instead focuses only on users who have attained the age of majority. The issue of informed consent by mentally ill minors is a complex area of study, no doubt worth researching on its own, and including it in a sub-section of the present dissertation would not do the topic justice.
- Historical references will be kept to an absolute minimum.

1.3 Approach and methodology

1.3.1 Approach to research, sources and references

The analysis of the research questions will be done at the hand of a “multi-layered approach”, meaning that each issue will be addressed in the context of the constitution, governing legislation, common law and “soft law” such as professional guidelines and ethics.⁴

Primary sources will be consulted as a starting point. For the most part this would include case law and legislation, with most focus being on the MHCA and Regulations and other concurrently applicable legislation, read in context of the constitution. The study will not extend to legal comparison, but brief mention will be made of international law and foreign law where relevant, particularly in the context of section 39(1) of the constitution.

Much of the research will also be based on secondary sources. Wherever available, academic textbooks will be consulted. Textbooks will be heavily relied upon for purposes of researching the clinical aspects of the study. In this respect, clinical

⁴ Carstens PA & Pearmain DL (2007) *Foundational principles of South African medical law* 1.

psychiatric textbooks as well as diagnostic- and classification manuals such as the different editions of the Diagnostic and Statistical Manual of Mental Disorders (the “DSM”) and the International statistical classification of diseases and related health problems (the “ICD”) will be consulted. Where relevant, reference will be made to the obsolete fourth edition of the DSM, the DSM-IV-TR. The reason for this is partly because the fifth edition, the DSM-5, is still fairly new and much of the other available research material still refers to the previous edition. It also relates to the DSM-5’s obvious lack of popularity among practitioners, with some preferring to simply continue using the DSM-IV-TR, or to employ ICD-codes as an alternative.

An overview of the literature revealed a dearth of publications dedicated specifically to the MHCA,⁵ owing to which much of the information about the MHCA will be derived from academic journal articles.

An empirical element will be brought to the study in order to supplement the legislative- and text analysis and to gain a more in-depth and practical understanding of the administrative procedures involved in the implementation of the MHCA (in particular chapter V thereof). The empirical element will involve consultation with members of the Secretariat and Mental Health Review Board in the Gauteng Province, and with private mental health care practitioners. Owing to time constraints, this aspect will be limited to the Gauteng Province and will not extend to the remaining provinces.

The internet will be utilised for its ability to provide some of the most up-to-date information pertaining to the research topic. To a limited extent, and where necessary to obtain background information of relatively new colloquial terms or certain cultural trends, internet search engines such as “google” may be utilised. This will not be specifically referenced in the study.

⁵ An exception being the recently-published Landman AA & Landman WJ (2014) *A practitioner’s guide to the Mental Health Care Act*.

1.3.2 Division of chapters

The research material will be divided into eight chapters, at the hand of the research questions outlined above. The chapters will be arranged as follows.

Chapter 1 will serve as an introduction to the study.

Chapter 2 will deal with principles and paradigms underling the MHCA. Specifically, it will be demonstrated how the MHCA complies with international mental health care standards, accords with constitutional principles while protecting and elaborating upon constitutional rights, and how it reflects, and in some instances, elevates to the status of law, and certain ethical principles regarding informed consent.

Chapter 3 will provide a basic, general framework of informed consent in terms of the common law, relativized to the context of mental health care. The overview will pertain to adult patients and consent and informed consent by minors will not be discussed for purposes of the study.

Chapter 4 will provide a short explanation of instances where it is unnecessary to obtain the informed consent of patients, in other words, of alternative grounds of justification. The chapter will not address treatment-provision in terms of the MHCA in any detail.

Chapter 5 will discuss the provisions of the MHCA, insofar as they have relevance to informed consent by mentally ill persons. The chapter will provide an overview of the MHCA's underlying goals and aims, following which the focus will shift to the procedures outlined in chapter V of the Act. The categories of voluntary-, assisted-

and involuntary mental health care users will be discussed, with the focus being on the latter two categories of user. Again, treatment-provision to mental health care users who are under the age of eighteen years will not be discussed as part of the chapter.

Chapter 6 will comprise a discussion of clinical aspects relevant to informed consent in mental health care law, with specific reference to Chapter V of the MHCA.

Chapter 7 will aim to make a few practical suggestions aimed at improving upon certain procedural and logistic problems in the mental health system, as revealed during the course of the study. The suggestions will relate to proposed amendments to the Act, as well as proposed informed consent- and disclosure documents for use in the psychiatric context.

Chapter 8 will be the conclusion to the work, and will provide a brief summary of the research and final conclusion to the research findings.

1.4 Definitions and explanations

1.4.1 Capacity and competence

A distinction is sometimes made between the terms “capacity” as a clinical state, and “competence” as an exclusively legal concept.⁶ The terms are used interchangeably throughout this study.

⁶ Kim SYH (2010) *Evaluation of capacity to consent to treatment and research* 17, 191.

1.4.2 Consequentialist ethics

Consequentialist ethics are normative ethical theories which judge an act's moral rightness in terms of whether it produces good consequences, rather than on account of their inherent nature or "rightness"⁷ (the "good" is considered more important than the "right").⁸ It includes Hippocratic ethics, social consequentialist ethics and utilitarianism.⁹

1.4.3 Deontological ethics

Deontological ethics refers to normative ethical theories which evaluate actions based on their inherent "rightness"¹⁰ rather than their consequences (making the "right" choice is more important than doing what is inherently "good").¹¹ Immanuel Kant is an example of a philosopher who considered the moral "rightness" of an act to be vested in the principle upon which it was performed, and not on its effects on other people – hence deontological ethics are sometimes said to have a Kantian basis.¹²

⁷ Veatch RM (2003) *The basics of bioethics 2nd Ed* 61; Sinnott-Armstrong W 'Consequentialism' in *The Stanford Encyclopedia of Philosophy* (ed Zalta EN) (2011), available at <http://plato.stanford.edu/archives/spr2014/entries/consequentialism/> (accessed 3 November 2014). The same argument is advanced in John Stuart Mill's Utilitarian moral philosophy - Wilson F 'John Stuart Mill' in Zalta EN (ed) (2007) *The Stanford Encyclopedia of Philosophy*, available at <http://plato.stanford.edu/archives/spr2014/entries/mill/> (accessed 3 November 2014).

⁸ Alexander L & Moore M 'Deontological ethics' in *The Stanford Encyclopedia of Philosophy* (ed Zalta EN) (2012), available at <http://plato.stanford.edu/archives/win2012/entries/ethics-deontological/> (accessed 3 November 2014).

⁹ Veatch 61.

¹⁰ "Deontology" derives from the Greek words for "duty" (*deon*) and "science" or "study" (*logos*) - Alexander & Moore <http://plato.stanford.edu/archives/win2012/entries/ethics-deontological/>.

¹¹ Veatch 61.

¹² Alexander & Moore <http://plato.stanford.edu/archives/win2012/entries/ethics-deontological/>.

1.4.4 Psychiatry and psychology

Psychiatrists and psychologists are sometimes confused with one another. While each is classified as a type of “mental health care practitioner”¹³ in terms of the MHCA, each has a different professional background and fulfils a different role in the therapeutic process.

The psychiatrist is a medical doctor who has chosen to specialise in the field of psychiatry. He*¹⁴ would have graduated with a medical degree (MB Ch.B. or MB B.Ch.), completed an internship and worked for at least two years as general practitioner.¹⁵ In order to specialise, the doctor would then complete a four-year registrar training programme at an academic psychiatry department, while working full-time at a state psychiatric institution.¹⁶ After passing a two-part examination, he would be admitted to the M.Med university degree (specialising in psychiatry), or College of Psychiatry fellowship (FCPsych(SA)).¹⁷ Upon completing either of these qualifications, he would become entitled to register as a psychiatrist.¹⁸ The

¹³ S1(xvii) of the MHCA defines “mental health care practitioner” as including not only a psychiatrist and psychologist, but also a registered medical practitioner, nurse, occupational therapist or social worker, who has been trained in the provision of mental health care. The extended category facilitates access to mental health care services – Zabow 60.

¹⁴ For the sake of simplicity, the male gender pronoun “he” will be used throughout the study. This is in no way meant to exclude female practitioners, mental health care users or individuals, or persons who identify with any other gender or no gender, from the principles discussed. To the contrary, the author views the particular choice of language as a manifestation of her own feminist beliefs, and trusts that like-minded readers will relate.

¹⁵ Kaliski S ‘Appendix: Mental health care practitioners: the psychiatrist’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 377 at 377-378. The psychiatrist is qualified to conduct physical examinations, which is relevant to S27(4)(b), 33(4)(b) and 34(1)(b) of the MHCA. For similar reasons, the input of a psychiatrist can be invaluable in identifying medical, surgical or neurological conditions as the cause of psychiatric symptoms – Sadock BJ & Sadock VA (2007) *Kaplan & Sadock’s Synopsis of psychiatry 10th Edition* 248.

¹⁶ Kaliski 377.

¹⁷ Kaliski 377.

¹⁸ Registration with the HPCSA takes place in accordance with S17 of the Health Professions Act 56 of 1974 (hereafter the “HPA”). Either the M.Med with specialisation in psychiatry or the FCPsych(SA) is considered a sufficient qualification for purposes of S17(4). See also Swanepoel M *Law, psychiatry and psychology: a selection of constitutional, medico-legal and liability issues* (unpublished LLD dissertation) UNISA (2009) 94.

psychiatrist may sub-specialise in biological psychiatry, child psychiatry and forensic psychiatry, psycho-genetics or another special field of interest.¹⁹

The psychologist is not a medical specialist, but someone who has studied in the social sciences.²⁰ He would have completed an undergraduate university degree (often a BA or BSc) majoring in psychology, followed by an Honours- and Master's degree in psychology.²¹ He would then become entitled to register and practice as psychologist with the HPCSA.²² Further study towards a Doctorate in psychology (either a DPhil or PhD (Psychology)) is not compulsory for registration.²³ Although they are not formal registration categories, many psychologists choose to specialise in neuropsychology, child psychology, criminal profiling or other fields.²⁴

1.5 Conclusion

This chapter has addressed a few preliminary issues that will be dealt with in more detail in the remainder of the study. As each issue is dealt with in turn, more specific problems should become apparent and toward the end of the study some practical suggestions will be made regarding ways in which they may be dealt with.

¹⁹ Carstens & Pearmain 746.

²⁰ Carstens & Pearmain 746; see also in general the University of Pretoria, Faculty of Humanities, Department of Psychology (2014) *Booklet on Career opportunities with psychology as a discipline* (hereafter referred to as “*Career opportunities - psychology*”), available at: <http://web.up.ac.za/sitefiles/file/46/1380/2014%20-%20Psych%20Booklets/2014%20-%20Psych%20Booklet%20-%20Eng.pdf> (accessed 1 July 2014).

²¹ *Career opportunities – psychology* 2, 18, 22. The Honours degree lasts one year and the Master's degree generally three to four years. The Master's degree includes community service.

²² Like the psychiatrist, the psychologist registers in accordance with S17 of the HPA. See also Lay S 'Appendix: mental health practitioners: the clinical psychologist' *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 378 at 378; *Career opportunities - psychology* 11 & 21. The psychologist may register as a Clinical-, Educational- or Research psychologist with the HPCSA.

²³ *Career opportunities - psychology* 21.

²⁴ *Career opportunities - psychology* 21.

In addition to the research aims and research questions, the chapter has briefly described the approach and methodology which will be followed, and has provided selected explanations of terms used throughout the remaining chapters.

Chapter 2

The right to be wrong: principles and perspectives underlying informed consent in mental health care law

The patient has a right to be different. The patient has a right to be wrong.¹

2.1 Introduction and background

In the global era of human rights and in view of the supremacy of the South African constitution (the “CRSA”),² the human rights underpinning to informed consent lies at the heart of a proper interpretation and understanding of informed consent in the context of mental health law. The Mental Health Care Act (the “MHCA”)³ conforms to international standards of mental health care, principles and rights contained in the CRSA and biomedical ethical principles.

The aim of this chapter is to demonstrate how the MHCA protects and promotes the human- and health rights of mental health care users (“users”) through the incorporation of international standards of mental health care, constitutional principles and principles of biomedical ethics.

¹ Ackermann J, citing Giesen D (1988) *International medical malpractice law: A comparative law study of civil liability arising from medical care* in *Castell v de Greef* 1994 at 421I-J.

² S2 of the Constitution of the Republic of South Africa, 1996 (the “CRSA”).

³ 17 of 2002, as amended (hereafter the “MHCA”).

An overview will be rendered of the role of international human rights instruments and international guidelines for mental health care law in shaping the current landscape of mental health care in South Africa. Specific rights of users contained in the MHCA will be discussed with reference to the CRSA, international guidelines, common law and ethics.

Following this, some ethical guidelines will be discussed for making justifiable infringements on a user's rights, including professional ethical guidelines for medical interventions without consent and other guiding principles as reflected in the MHCA's provisions.

2.2 International human rights and standards of mental health care law

2.2.1 The role of international law in South African mental health care law

In terms of section 39(1) of the CRSA, binding as well as non-binding international law may be used to aid interpretation of the South African Bill of Rights.⁴ This is of particular importance in the context of mental health care, which has been influenced to a great extent by public international law,⁵ especially where a scarcity of reported case law exists.

⁴ Currie I & de Waal J (2013) *The Bill of Rights Handbook 6th Edition* 117, 146-147; *S v Makwanyane and Another* 1995 (2) SACR 1 (CC) at 24-25.

⁵ The MHCA is in line with constitutional- and international human rights standards – Freeman M 'New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health' (2002) *South African Psychiatry Review* 4 at 4-5; Zabow T 'The Mental Health Care Act (Act 17 of 2002)' in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 58 at 58.

2.2.2 The African (Banjul) Charter on Human and Peoples' Rights

The African (Banjul) Charter on Human and Peoples' Rights ("ACHPR")⁶ is a regional treaty which has been ratified by South Africa, and which was specially devised for the protection of the human rights in general, of people on the African continent.⁷ The ACHPR supports informed consent and autonomy by ensuring the right to respect for life and integrity of one's person;⁸ the right to liberty and security of the person;⁹ freedom of movement,¹⁰ and the right to enjoy the best attainable state of physical and mental health.¹¹ The ACHPR further states that the individual must exercise his rights in a manner that takes into consideration the rights of others, the collective security, morality and common interest,¹² which may be taken to suggest that individual rights may be limited if doing so is in the interest of the collective.

2.2.3 The Universal Declaration of Human Rights

The United Nations Universal Declaration of Human Rights (the "Universal Declaration"),¹³ was approved by the United Nations General Assembly in 1948.¹⁴ The Universal Declaration is not legally binding on states, but is a recommendatory resolution which aims to set the "common standard of achievement for all peoples

⁶ Organization of African Unity (OAU) *African (Banjul) Charter on Human and Peoples' Rights* (1981), available at <http://www.achpr.org/instruments/achpr/> (accessed 31 October 2014) (the "ACHPR").

⁷ Dugard J (2010) *International law: A South African perspective 3rd Ed* 557-558; Landman AA & Landman WJ (2014) *A practitioner's guide to the Mental Health Care Act* 24.

⁸ Art 4 of the ACHPR.

⁹ Art 6 of the ACHPR.

¹⁰ Art 12 of the ACHPR.

¹¹ Art 16 of the ACHPR. Art 4, 6 and 9 reflect the principle of autonomy; while Art 16 reflects the bioethical principle of beneficence. Dhai A & McQuoid-Mason D (2011) *Bioethics, human rights and health law: Principles and practice* 39 & 42.

¹² Art 27 of the ACHPR.

¹³ United Nations (1948) *The Universal Declaration of Human Rights*, available at <http://www.un.org/en/documents/udhr/> (accessed 2 October 2014) (the "Universal Declaration"). The Universal Declaration forms part of the United Nations *International Bill of Human Rights*, available at <http://www.ohchr.org/Documents/Publications/Compilation1.1en.pdf> (accessed 2 February 2015).

¹⁴ Dugard 314; Landman & Landman 22.

and all nations”.¹⁵ Of its thirty general articles, those most relevant to the right to autonomy and self-determination are the right to freedom and equality in terms of dignity and rights;¹⁶ the right to life, liberty and security of person;¹⁷ the right to freedom of movement,¹⁸ and the right to an adequate standard of living, including medical care and social services.¹⁹

2.2.4 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

Among its specialised documents, the United Nations drafted the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (the “UN Principles”).²⁰ The principles were drafted with the dual purpose of protecting the rights of mentally ill persons as a vulnerable group, and at the same time facilitating the improvement of mental health care.²¹ The principles would serve as a framework at the hand of which member states could formulate or adapt their mental health laws.²² The principles are not an international treaty and are therefore not legally binding upon United Nations member states. They do, however, carry a greater legal significance than a simple recommendation.²³

¹⁵ Dugard 314.

¹⁶ Art 1 of the Universal Declaration.

¹⁷ Art 3 of the Universal Declaration.

¹⁸ Art 13 of the Universal Declaration.

¹⁹ Art 25 of the Universal Declaration.

²⁰ United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* adopted by the UN General Assembly Resolution 46/199 of 17 December 1991, available at <http://www.un.org/documents/ga/res/46/a46r119.htm> (accessed 2 October 2014) (the “UN Principles”).

²¹ Gendreau C ‘The rights of psychiatric patients in the light of the principles announced by the United Nations: a recognition of the right to consent to treatment?’ (1997) 20 *International Journal of Law and Psychiatry* 259 at 264.

²² Gendreau (1997) *International Journal of Law and Psychiatry* 263.

²³ Gendreau (1997) *International Journal of Law and Psychiatry* 265-266.

2.3 The MHCA: specific rights of mental health care users

In spite of the stigma and marginalisation associated with psychiatric disorder,²⁴ the human rights of mentally ill persons are the same as those of any other people.²⁵ The World Health Organisation (“WHO”) document entitled *Mental Health Care Law: Ten Basic Principles* is based in part on the UN Principles, and provided much of the groundwork for the MHCA, particularly in terms of users’ rights.²⁶ Many of the rights and duties of mental health care users as contained in chapter III of the MHCA also reflect fundamental human rights found in the CRSA and accordingly enjoy constitutional status.²⁷ Some users’ rights, notably the right to security of the person, has been acknowledged in terms of the common law for a long time prior to the enactment of the MHCA. These are reaffirmed in terms of the MHCA. Other rights contained in the MHCA elevate ethical principles to the status of legal rights.²⁸ Selected users’ rights contained in the MHCA, specifically those most relevant to informed consent, are subsequently discussed further.

2.3.1 The right to autonomy and security of the person

Individualism and freedom of the individual are embodied in the maxim of *volenti non fit iniuria*: the patient gets to decide what is to be done with his body and gets to decide to waive the right to security of the person, should he wish to do so.²⁹

²⁴ Swanepoel M Law, *psychiatry and psychology: a selection of constitutional, medico-legal and liability issues* (unpublished LLD dissertation) UNISA (2009) 92.

²⁵ Zabow 61. See also S9 of the CRSA S10 of the MHCA; Dada MA & McQuoid-Mason DJ (eds) (2001) *Introduction to medico-legal practice* 103.

²⁶ World Health Organisation, Division of Mental Health and Substance Abuse, *Mental Health Care Law: Ten Basic Principles* (WHO/MND/96.9), Geneva, 1996, available at http://www.who.int/mental_health/policy/legislation/ten_basic_principles.pdf (accessed 2 February 2015) (the “WHO Principles”). Landman & Landman 3. See also Freeman (2002) *South African Psychiatry Review* 5.

²⁷ Landman & Landman 25.

²⁸ Landman & Landman 26.

²⁹ Parmarand S ‘The consenting plaintiff and the *boni mores*: the proper perspective’ (1986) 3 *Journal of South African Law* 338 at 339-340. From a theoretical viewpoint Immanuel Kant’s views strongly

Respect for autonomy relates to the fundamental right of self-determination and informed consent.³⁰

The WHO Principles affirm the right to self-determination and consent by recommending that informed consent should be required before “any type of interference” with the patient is permitted.³¹ The right to autonomy and self-determination is also a constitutional right, entrenched in section 12 of the CRSA.

Section 12 of the CRSA ensures the right to bodily and psychological integrity, decisions about reproduction, security in and control over one’s own body.³² It is “the right to be left alone”.³³ Section 12(2)(b), in particular, protects the right to personal autonomy in medical treatment in that it protects the right to security in and control over one’s body.³⁴ The right extends to both physical and psychological integrity, and leaves no doubt as to the fact that personal autonomy – the right to make one’s own decisions about one’s own body – enjoys constitutional status.³⁵ The right to freedom and security of the person includes both substantive and

affirm individual autonomy, since they support the notion that respect for autonomy is the natural result of the acknowledgement of each person’s unconditional worth and capacity to determine the course of their own lives. Each person should be treated as an end in themselves and not a means to an end. See Veatch 73; Beauchamp TL & Childress JF (2001) *Principles of biomedical ethics 5th Ed* 63-64; Kant I ‘Fundamental principles of the metaphysic of morals’ in *Moral philosophy: an introduction* (Glickman J ed) (1976) 392 at 421. Similarly, John Stuart Mill’s “individuality” is based upon the premise is that the individuality and right to self-determination of every person should be respected, allowing them to live according to their convictions, bearing in mind that this freedom must be interfered with if the individual were to hold and live by “ill-considered views” – Beauchamp & Childress 64.

³⁰ Giesen D ‘From paternalism to self-determination to shared decision making’ (1988) *Acta Juridica* 107 at 116; Nienaber A ‘The regulation of informed consent to participation in clinical research by mentally ill persons in South Africa: An overview’ (2010) 16 *South African Journal of Psychiatry* 118 at 118.

³¹ Landman & Landman 6. Also UN Principles 1 & 11.

³² Also Landman & Landman 26.

³³ Currie & de Waal 287.

³⁴ Currie & de Waal 286. S12(1)(b) should be read with S12(1)(c), which encompasses the right to be free from violence from both state- and private sources. This is of relevance in the context of the provision of medical treatment in the absence of informed consent as assault – see Claassen NJB & Verschoor T (1992) *Medical negligence in South Africa* 72; Carstens & Pearmain 497-500.

³⁵ This right extends to medical treatment and reproductive decisions – as evident from the Choice on Termination of Pregnancy Act 92 of 1996 and the matter of *Christian Lawyers’ Association v Minister of Health* 2005 (1) SA 509 (T).

procedural aspects, in that it requires a good reason for infringing upon or depriving someone of the right, as well as a fair procedure in making the infringement or deprivation.³⁶

The MHCA protects these rights by allowing every user the right to decide for himself whether to give consent to mental health treatment.³⁷ Section 9 of the MHCA forbids treatment-provision in the absence of informed consent, unless authorised by a court order or Mental Health Review Board, or in the event of psychiatric emergency treatment. Even emergency treatment, however, may not continue for longer than twenty-four hours unless application is made for continued treatment in terms of chapter V.³⁸

The MHCA goes further to give user the right to be assisted in exercising the right to autonomy, by affording him the right to be informed of rights without delay once detained and prior to any treatment; the right to consult with legal practitioner and the right to representation during appeal procedures, applications or when having to appear before a magistrate, court or the relevant Mental Health Review Board.³⁹

The acknowledgement of the right to autonomy, self-determination and security of the person, have been protected in terms of the common law for a long time before the enactment of the MHCA. In the matter of *Stoffberg v Elliott*,⁴⁰ the plaintiff was admitted to hospital in order to have surgery performed upon his cancerous penis. During the operation, the defendant found that the condition was more serious than

³⁶ Currie & de Waal 270.

³⁷ Landman & Landman 31.

³⁸ Landman & Landman 31-32.

³⁹ Landman & Landman 6-7.

⁴⁰ 1923 CPD 148.

he had initially thought and proceeded to amputate the plaintiff's penis entirely. The instruction of Watermeyer J to the jury speaks for itself:⁴¹

In the eyes of the law, every person has certain absolute rights which the law protects. They are not dependent upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person. Nobody can interfere in any way with the person of another, except in certain circumstances which I will further explain to you...⁴²

The judgement has been subject to constitutional scrutiny in relation to the phrase "absolute security of the person", which does not at first glance mean the same as the "right of absolute security of the person" as found in section 12(2)(b) of the CRSA.⁴³ The co-existence of the constitutional right which is subject to limitations in terms of sections 36 and 7(3) of the CRSA, and a common law right which is absolute would not be feasible.⁴⁴ In order for the two rights to co-exist, they should be interpreted in such a way that harmonises the two meanings.⁴⁵ It has been suggested that the word "absolute" in the context of the *Stoffberg* judgement has best be interpreted as relative.⁴⁶ This allows the common law right to adopt basically the same meaning as that of the constitutionally enshrined right, so that neither of the two is absolute.

The case of *Ex parte Dixie*,⁴⁷ in turn involved a patient diagnosed as suffering from "paranoid schizophrenia" and detained in terms of the Mental Disorders Act of 1916. His illness rendered him incapable of consenting to medical- and mental health

⁴¹ Both sadly and ironically, though, the jury enters judgement against the plaintiff. Their decision seems to have been based on the premise that because the plaintiff would have soon died of penile cancer in any event without the amputation, he did not suffer any damage.

⁴² *Stoffberg* at 148.

⁴³ Carstens & Pearmain 880.

⁴⁴ S39(3) of the CRSA permits reliance on a common law right, as long as this right does not conflict with constitutional provisions. See also Currie & de Waal 148.

⁴⁵ Carstens & Pearmain 882.

⁴⁶ Carstens & Pearmain 881-882.

⁴⁷ 1950 4 SA 748 (W).

treatment and at times resulted in such agitated and aggressive behaviour as to preclude family visits. Doctors at the Sterkfontein hospital believed that it would benefit the patient to undergo psychiatric treatment in the form of a leucotomy.⁴⁸ The procedure would reduce his aggression and agitation and improve his quality of life, although it would not “cure” him of his mental illness. Millin J ruled that:

[s]uch an operation cannot lawfully be performed without the consent of the patient, or, if he is not competent to give it, that of some other person in authority over his person. The fact that he is a patient in this hospital does not entitle those in charge of it to perform any surgical operation upon him which they may consider beneficial. They would only be justified in performing a major operation without proper consent where the operation is urgently necessary and cannot, with due regard to the patient’s interests, be delayed.⁴⁹

The *locus classicus* on patient autonomy and the right to informed consent in South African medical law, is the matter of *Castell*.⁵⁰ In this case the plaintiff, a middle-aged woman, was advised to undergo a double subcutaneous mastectomy and transpositioning of the areolae on account of a diagnosis of breast cancer. The surgery left her with unsightly scars and improperly repositioned areolae, in addition to which she developed *staphylococcus aureus* infection and necrosis which led to the loss of her one entire nipple and part of the other.

In its judgement, the court strongly emphasises the constitutionally embodied right to physical integrity, self-determination, and autonomy is strongly emphasised,⁵¹ and affirms that the patient, and not the doctor, should be allowed to decide about whether or not an operation should be performed.⁵² It is in this judgement where

⁴⁸ A leucotomy (also called a “leukotomy” or “prefrontal lobotomy”) is a form of psychosurgery which involves making an incision of the frontal lobe is with a leukotome, which is passed through a cannula through holes drilled into the front part of the skull – see Dorland *Dorland’s Illustrated Medical Dictionary* 32nd Ed (2012) 1026 & 1070.

⁴⁹ *Ex parte Dixie* at 751C.

⁵⁰ *Castell v de Greef* 1993 (3) SA 501 (C) & 1994 (4) SA 408 (C).

⁵¹ Carstens & Pearmain 882.

⁵² *Castell* 1994 at 420J-423A. The choice between informed consent or informed refusal should be that of the patient – Carstens & Pearmain 882.

the court affirms that, on account of the right to autonomy and self-determination, in principle every patient should have the “right to be wrong”.⁵³

Respect for autonomy is also an ethical principle, with respect for autonomy being one of the four tenets of biomedical ethics.⁵⁴ As a moral principle, autonomy means the duty to respect autonomous persons’ choices.⁵⁵ It may also refer to a deontological moral principle which considers actions or rules to be “right” as long as they respect people’s autonomous choices.⁵⁶ Respect for autonomy involves the acknowledgement of an autonomous person’s right to their own opinions and choices, which they may hold and make according to their own personal values and convictions.⁵⁷ Both a positive and negative duty are imposed, namely refraining from interference with the patient’s exercise of the right to autonomous choices, and the promotion of autonomous action, for example through the provision of adequate information.⁵⁸

A person, whether they are in good health or whether they are ill, dependent and in need of assistance, should have the assurance that their physical and psychological integrity will not be interfered with without their permission, even if the interference is done with the aim of promoting their health.⁵⁹ The patient who has the capacity

⁵³ Ackermann J, citing Giesen in *Castell v de Greef* 1994 at 421I-J.

⁵⁴ The other three are beneficence, nonmaleficence (the principle of *primum non nocere* or “first do no harm”), and justice (the equitable distribution of resources) – Segal J & Thom R ‘Consent procedures and electroconvulsive therapy in South Africa: impact of the Mental Health Care Act’ (2006) *South African Psychiatry Review* 206 at 206; Zabow T & Kaliski S ‘Ethical considerations’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 357 at 358.

⁵⁵ Veatch RM (2003) *The basics of bioethics 2nd Ed* 84.

⁵⁶ Veatch 84.

⁵⁷ Respect for persons and for the personal autonomy of rational human beings is central to the work and theory of Immanuel Kant - Johnson R ‘Kant’s Moral Philosophy’ in Zalta EN (ed) *The Stanford Encyclopedia of Philosophy* (2008), available at <http://plato.stanford.edu/archives/sum2014/entries/kant-moral/> (accessed 3 November 2014); Zabow & Kaliski 358.

⁵⁸ Beauchamp & Childress 63-64.

⁵⁹ Giesen (1988) *Acta Juridica* 116.

to do so, is entitled to make their own health-related decisions, even if the decision seems unreasonable to doctors, family members or other people.⁶⁰

Beneficence, which is sometimes seen as the principle opposing respect for autonomy, describes the aim of acting in a manner which promotes the welfare and well-being of the patient, and may involve the weighing up of benefits and risks involved in a particular act in order to procure the best end result; such as deciding whether a harm inherent in a procedure would be worth risking for the sake of the good which can be achieved.⁶¹ It is essentially about a moral obligation to act in a way that benefits other people.⁶²

Paternalism refers to acts performed for the benefit or to promote the well-being, of another person.⁶³ It is based upon the biomedical ethical principle of beneficence, which endorses actions that produce “good” consequences.⁶⁴ Sometimes a distinction is drawn between “strong paternalism”, where beneficial acts are performed even against a mentally competent person’s will, and “weak paternalism”, where the acts are performed towards a mentally incapacitated individual.⁶⁵ In contrast to recent trends, traditional medical ethics values the *salus* (the health and well-being) over the *voluntas* (the right to decide what will be done with his own body) of the patient.⁶⁶ It has strong undertones of medical paternalism, or the notion that the “doctor knows best”.⁶⁷

⁶⁰ Van Oosten (2000) *THRHR* 24; *Castell* 1994 at 420-421.

⁶¹ Zabow & Kaliski 358; Beauchamp & Childress 166.

⁶² Beauchamp & Childress 166.

⁶³ Veatch 62.

⁶⁴ Veatch 61.

⁶⁵ Veatch 62.

⁶⁶ Giesen (1988) *Acta Juridica* 109.

⁶⁷ Medical paternalism is seen in the Hippocratic Oath, still frequently taken by medical graduates, where the physician vows to “...use treatment to help the sick according to [his] ability and judgement...” or to “...follow that system of regimen which, according to [his] ability and judgment, [he] consider[s] for the benefit of [his] patients...”. The exact wording depends on the version of the

In terms of “soft law” and ethical guidelines the National Patients’ Rights Charter provides a further example of an ethical guideline affirming the right of every person to participate in decisions which affect their own health.⁶⁸ The National Patients’ Rights Charter explicitly provides for the right to informed consent and the right of the patient to refuse treatment, as long as such refusal does not pose a threat to the well-being of other persons.⁶⁹

2.3.2 The right to personal liberty and freedom of movement

Users have the right to freedom and security of the person, meaning that a user cannot be deprived of freedom without good reason,⁷⁰ and related to this, the right to freedom of movement and residence.⁷¹ An example of how the MHCA respects these rights is through imposing stringent regulations on the seclusion of users,⁷² and as discussed below, provides for least restrictive treatment by allowing involuntary outpatient treatment instead of involuntary inpatient treatment, if appropriate for the user.

Oath. See Schwär TG, Olivier JA & Loubser JD (1988) *The forensic ABC in medical practice: a practical guide* 8; Giesen 670.

⁶⁸ Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: National patients’ rights charter* Pretoria: Health Professions Council of South Africa, available at

http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_3_patients_rights_charter.pdf (accessed 29 October 2014) (the “Patients’ rights charter”) at par 2.2.

⁶⁹ Par 2.8 and 2.9 of the *Patients’ rights charter*, respectively.

⁷⁰ S12 of the CRSA; Landman & Landman 26.

⁷¹ S21 of the CRSA. This right becomes relevant in terms of refusal of hospital treatment and voluntary discharge from a psychiatric establishment – McQuoid-Mason D & Dhali A ‘Health and human rights’ in Dhali A & McQuoid-Mason (2011) *Bioethics, human rights and health law: principles and practice* 35 at 39.

⁷² Reg 37 contained in the General Regulations to the MHCA, published under GN R1467 in GG 27117 of 15 December 2004 as corrected by GN R98 in GG 27236 of 11 February 2005; Landman & Landman 26-27.

2.3.3 The right to least restrictive treatment

It has already been made clear that the provision of medical treatment, including mental health treatment may constitute a violation of several of the patient's fundamental human rights, which will be unlawful in the absence of informed consent or, failing that, of another legally valid excuse.⁷³

International guidelines of mental health care emphasise the least restrictive environment or "least restrictive means"⁷⁴ and "best interests of the user"⁷⁵ as guiding principles in making decisions about justified infringement on users' rights.⁷⁶ For instance WHO Principle 4 calls for mental health treatment-provision of whatever kind is least restrictive, and likewise UN Principle 1 prescribes that one should take into consideration the type of mental disorder, the available types of treatments, person's level of autonomy, person's acceptance of treatment and willingness to cooperate and the harm person may cause, in making decisions about the type of mental health treatment to provide. UN Principles 3, 7 & 9(1) recommend that mentally ill persons should be provided with community treatment rather than inpatient treatment wherever possible, and that where inpatient treatment is necessary, it should still be provided in a way that is as non-restrictive as possible.

⁷³ Carstens & Pearmain 871.

⁷⁴ Infringements on the individual's autonomy must be limited to the least extent needed to achieve the goal of protecting society's interests. This accords with S36(1)(e) of the CRSA and S8(3) of the MHCA, as well as common law principles. See Moosa & Jeenah (2008) *African Journal of Psychiatry* 109; Freeman (2002) *South African Psychiatry Review* 7; Van der Walt JC & Midgley JR (2005) *Principles of delict* 3rd Ed 143-144; SANTAM; Neethling *et al* 108.

⁷⁵ This principle implies that maximum self-determination and independent decision-making should be allowed for, and that the patient's best interests should be kept mind in major decisions affecting him. Freeman (2002) *South African Psychiatry Review* 5; Zabow 61. The principle is supported by the provisions of Chapter III of the MHCA, and by par 10.1.1-10.1.5 of the Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: Seeking patients' informed consent: The ethical considerations* available at http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf (accessed 2 September 2014) (hereafter the "HPCSA Guidelines on seeking patients' informed consent"), where the "best interests" principle is affirmed in respect of users. The user's autonomy is acknowledged by taking into consideration his previously expressed wishes, background, treatment which least restricts his future options.

⁷⁶ Landman & Landman 5.

In South African context, any law or conduct should stand scrutiny against the CRSA if they are to be of any relevance in the post-constitutional era. It is imperative that traditional common law- and other justifications be relativized to constitutional principles, rather than being viewed in isolation.⁷⁷ An infringement (or justifiable infringement) on a right can be viewed as another way of describing a limitation of that right.⁷⁸ In order to be constitutionally justified, such a limitation must have sufficiently strong rationale –⁷⁹ more specifically, it must stand against the “two-stage” constitutional evaluation of justifiability.⁸⁰

The “first step” evaluates whether the limitation is taking place in terms of a law of general application.⁸¹ A law which provides that mentally ill persons, merely by virtue of their mental illness, should be deemed incapable of making mental health related decisions and therefore automatically incapable of giving informed consent, would infringe upon their constitutional rights, most notably the right to freedom and security of the person.⁸² It is submitted that in order to comply with the “first step” of the constitutional test, it will be necessary in terms of the MHCA to specifically assess the ability of the mentally ill person to make decisions about mental health care, at the time when they are expected to make this decision, prior to taking a decision such as that involving involuntary mental health treatment-provision.⁸³

The “second step” of the test evaluates whether the infringement is taking place for reasons that are considered reasonable and justifiable in an open and democratic

⁷⁷ Carstens & Pearmain 872.

⁷⁸ Currie & de Waal 151.

⁷⁹ Currie & de Waal 151.

⁸⁰ Currie & de Waal 155.

⁸¹ Currie & de Waal 155.

⁸² A law like this is likely to amount to unfair discrimination, albeit on an “unlisted ground”, namely mental illness or mental health status, in S9 of the CRSA as well – see Gendreau (1997) *International Journal of Law and Psychiatry* 268, where the issue of equality and discrimination is discussed in context of international law. See also S10 of the MHCA which specifically forbids unfair discrimination based on mental health status, and S1(xx) thereof for the definition of “mental health status”.

⁸³ This approach is in line with the “functional approach”, which is elaborated upon later in the study.

society based on human dignity, equality and freedom.⁸⁴ This broad requirement implies that there should be a constitutionally acceptable purpose for the infringement, and proportionality between the infringement (or harm) and the purpose (or benefits) thereof.⁸⁵ A standard of minimum infringement should be held, so that the limitation does not extend any further than what is needed to achieve its purpose.⁸⁶ Proportionality in this sense is evaluated at the hand of the factors stipulated in section 36 of the CRSA, namely: the nature of the right; the importance of the purpose of the limitation; the nature and extent of the limitation; the relation between the limitation and its purpose and less restrictive means to achieve the purpose of the limitation.⁸⁷ The factors do not comprise a closed list, checklist or standard test for proportionality, but rather a guideline to evaluate whether proportionality has been complied with.⁸⁸ The decision of whether an infringement is proportional would depend on the circumstances of each case.⁸⁹

The MHCA gives effect to the international recommendations, and is at least theoretically in line with the CRSA's limitations clause, in that it affords every user the right to mental health treatment that is proportionate to his mental health status, meaning that the intrusion associated with mental health treatment should be kept to the minimum necessary to effect the appropriate treatment.⁹⁰ For assisted- and involuntary users, frequent review procedures are available, which includes a re-assessment of whether the form of treatment they are receiving is still appropriate and proportionate.⁹¹

⁸⁴ Currie & de Waal 155.

⁸⁵ Currie & de Waal 163.

⁸⁶ Currie & de Waal 162-163.

⁸⁷ Currie & de Waal 163-164.

⁸⁸ Currie & de Waal 164.

⁸⁹ Currie & de Waal 164.

⁹⁰ S8(3) of the MHCA; Landman & Landman 32.

⁹¹ Landman & Landman 5.

2.3.4 The right to equality

Section 9 of the CRSA gives everyone the right to equality,⁹² and forbids unfair discrimination. Section 9(4) goes on to state that national legislation must be enacted in order to prevent unfair discrimination “against anyone on one or more grounds...”

The MHCA gives effect to this provision in that it specifically prohibits unfair discrimination based on mental health status.⁹³ In addition to the non-discrimination provision, the MHCA gives effect to the equality clause in the CRSA in that section 10(2) of the MHCA calls for equal standards of care, treatment and rehabilitation services to be provided to mental health care users, so that they receive the same standard of care as would any other type of patient.⁹⁴

2.3.5 The right to human dignity and privacy

Like any other person, users enjoy the constitutional rights to human dignity,⁹⁵ and privacy.⁹⁶ Respect for the person of the user,⁹⁷ their human dignity and privacy are reaffirmed by section 8(1) MHCA. Section 8(2) of the MHCA further requires that the user should be provided with services that assist him in developing his full

⁹² S9 of the CRSA. The equality clause and the prohibition on discrimination are closely related to the constitutional right to human dignity – Landman & Landman 39.

⁹³ S10(1) of the MHCA. See Landman & Landman 40-43 for a more detailed exposition of aspects regarding complaints of unfair discrimination on this basis. Mental health status is not specifically listed as an unfair ground of discrimination in terms of S9(3) of the CRSA itself.

⁹⁴ Landman & Landman 43.

⁹⁵ S10 of the CRSA. The right to dignity can be related closely to good health and quality of life – see Carstens & Pearmain 29.

⁹⁶ S14 of the CRSA. The right to privacy also relates to the Promotion of Access to Information Act 2 of 2000 (“PAIA”), the provisions of which regarding “personal information” includes information regarding a person’s mental health – S1 of the PAIA and Carstens & Pearmain 32; McQuoid-Mason & Dhai 39.

⁹⁷ See S12 of the CRSA.

potential and which facilitate integration into the community, and section 8(3) prohibits abuse of users, which also serves to protect users' dignity.⁹⁸

2.3.6 Other rights

Aside from those mentioned above, certain other users' rights are worth mentioning in the context of informed consent. In terms of the CRSA, users have the right to administrative action which is lawful, reasonable and procedurally fair.⁹⁹ This includes that users whose rights have been affected by administrative decisions should be given reasons for the decisions in writing – a right which is very relevant to administrative procedures provided for throughout the MHCA.¹⁰⁰ In accordance with the CRSA,¹⁰¹ principles 2 and 3 of the WHO Principles and UN Principle 1(1) and 15(1), users should be afforded access to basic health care and mental health care should be available to people who seek it voluntarily, just like other health care.¹⁰² In its efforts and aims at integration of mental health care at all levels and its increased emphasis on community care, the MHCA is seen to give effect to these provisions. Section 25 of the MHCA, relating to voluntary mental health treatment, further reflects the requirements of the CRSA, UN Principles and WHO Principles in this regard. Other rights in the Bill of Rights which may be affected by the MHCA's informed consent-related provisions include the right to life,¹⁰³ and property.¹⁰⁴

⁹⁸ Landman & Landman 31.

⁹⁹ S33 of the CRSA. This may be relevant together with the Promotion of Administrative Justice Act 3 of 2000 where the Mental Health Review Boards, these being administrative tribunals, are concerned. See Also Landman & Landman 29.

¹⁰⁰ Landman & Landman 29. Chapter V of the MHCA, for example, frequently refers to the head of establishment providing written reasons to an applicant.

¹⁰¹ S27 of the CRSA, including S 27(3) which encompasses the right to emergency medical treatment. Unlike some foreign jurisdictions, the CRSA does not define emergency medical treatment – Carstens & Pearmain 171.

¹⁰² Landman & Landman 4.

¹⁰³ S11 of the CRSA. According to the judgement in *Makwanyane* this includes the right, broadly speaking, to quality of life – see Carstens & Pearmain 27. The right to life is of particular relevance in the context of the right to refuse life-saving treatment – McQuoid-Mason & Dhai 39.

2.4 Balancing the *salus* and the *voluntas*: ethical aspects and challenges in the psychiatric context

Aside from international and constitutional guidelines, ethical rules exist for deciding on when an infringement on a mentally ill person's personal liberties is permissible. Psychiatrists have the same ethical goals and should conduct their practice with due regard for the patient's dignity and in accordance with the guidelines of the HPCSA, as other medical professionals.¹⁰⁵ The interpretation of the HPCSA's guidelines can be slightly more problematic in the context of mental health care, given the complexity of the psychiatric field and the often-conflicting ethical duties which the psychiatrist may be faced with.¹⁰⁶

The South African Society of Psychiatrists ("SASOP") confirms that the psychiatric profession is bound by the same basic ethical rules and guidelines stipulated in terms of the HPCSA.¹⁰⁷ SASOP is also part of the World Psychiatric Association ("WPA") Member Society,¹⁰⁸ which subscribes to the 'Principles of Medical Ethics of the American Medical Association and the Madrid Declaration of the World Psychiatric Association. The Madrid Declaration on Ethical Standards for Psychiatric Practice contains a number of provisions aimed at preserving the dignity and autonomy of psychiatric patients.¹⁰⁹

¹⁰⁴ S25 of the CRSA, in the sense that the property of a mentally ill or –disabled person may be placed under the control of an administrator or interim administrator in terms of Chapter VIII of the MHCA.

¹⁰⁵ Zabow & Kaliski 358.

¹⁰⁶ Zabow & Kaliski 358. An example of conflicting duties is the "dual agency" seen in the duty of confidentiality towards the patient, and the duty to inform third parties of possible danger posed by a patient – Zabow & Kaliski 361.

¹⁰⁷ South African Society of Psychiatrists (SASOP) (2014) *CPD Meetings, Standard Operating Procedure* http://www.sasop.co.za/C_DC_CPDeve_meetings.asp (accessed 29 October 2014).

¹⁰⁸ World Psychiatric Association *Member Societies*, available at http://www.wpanet.org/detail.php?section_id=5&content_id=674&sort_by=S (accessed 4 August 2014).

¹⁰⁹ World Psychiatric Association (2011) *Madrid Declaration on Ethical Standards for Psychiatric Practice*, available at http://www.wpanet.org/detail.php?section_id=5&content_id=48

What makes the interpretation of ethical rules in the psychiatric context particularly complex and challenging is the fact that, uniquely, the psychiatrist bears a duty towards the patient and community at the same time.¹¹⁰ This places the practitioner in the position of a type of “dual agency”, where he must take into account the interests of the individual patient as well as the community and third parties, which perhaps does not reflect the typical usual doctor-patient relationship.¹¹¹

The conflict between autonomy and beneficence (medical paternalism),¹¹² while not unique to mental health care, is particularly prominent in the psychiatric context where the patient often lacks the capacity to make informed decisions about their own mental health.¹¹³ Like the right to self-determination, the principle of respect for autonomy is not absolute, and may be superseded by other competing principles and considerations.¹¹⁴ If a person exercises their autonomy in a manner that endangers public health or third parties, their person’s right to have their autonomy respected may be limited on ethical grounds.¹¹⁵ Paternalistic infringements on patient autonomy may therefore be justifiable ethically, just as it may be justifiable legally.¹¹⁶

(accessed 11 November 2014). Among these, the provision that “[i]t is the duty of psychiatrists to provide the patient with all relevant information so as to empower the patient to come to a rational decision according to personal values and preferences”.

¹¹⁰ Zabow T ‘Competence and decision-making: Ethics and clinical psychiatric practice’ (2008) 1 *South African Journal of Bioethics and Law* 61 at 61.

¹¹¹ Zabow & Kaliski 361. See also *Tarasoff v Regents of the University of California* 83 ALR 3 rd 1166 (Cal 1976), and *Seema v Executive Member of Gauteng* 2002 (1) SA 771 (T) regarding the duty to warn and protect third parties against a psychiatric patient.

¹¹² Rather than viewing the two principles as being in opposition to one another, it has been suggested that they can be seen as complementary, with autonomy providing the frame within which beneficence (paternalism) may operate as the ultimate goal of medicine – Beauchamp & Childress 176-177.

¹¹³ Moosa & Jeenah 109; also Segal J & Thom R ‘Consent procedures and electroconvulsive therapy in South Africa: impact of the Mental Health Care Act’ (2006) *South African Psychiatry Review* 206 at 207 where the two principles are discussed in the context of consent to electroconvulsive therapy.

¹¹⁴ Beauchamp & Childress 57, 65; Mason JK, Laurie GT & Aziz M (2006) *Mason & McCall Smith’s Law and medical ethics 8th Ed* 64.

¹¹⁵ Beauchamp & Childress 65.

¹¹⁶ Beauchamp & Childress 179.

An important consideration, and one of the possible grounds on which paternalism may be justified, is that the cost of a person's illness is too great to society to allow them to make their own decisions.¹¹⁷ The mental health care practitioner may often find themselves in the situation where their patient, the mentally ill person, poses a threat to the community or to a person or property. The practitioner has the same professional duties towards the mentally ill patient as any other doctor towards any other patient, but at the same time, they have the duty to protect society against their patient if necessary.¹¹⁸

In certain instances the limitation of the patient's personal autonomy in favour of protecting the community will be justified, however, making this decision requires a fine balancing of interests to ensure that neither the patient nor the community is unfairly prejudiced.¹¹⁹

2.5 Conclusion

This chapter has sought to highlight the rights and principles underlying the provisions of the MHCA, with reference to international human rights instruments and standards of mental health care, the CRSA, pre-existing South African law and ethical principles. An effort was made to demonstrate how users' rights contained in international human rights instruments as well as specialised international guidelines and recommendations, have influenced the MHCA to a large extent. Specific rights of users were discussed, with focus on those basic rights which are the most relevant to the MHCA's informed consent provisions. It was shown that many of the rights afforded to users in terms of chapter III of the MHCA are extensions of constitutional rights, or ethical principles which have been elevated to the status of rights. In the case of autonomy and security of the person, which underlies

¹¹⁷ Mason *et al* 64; Moosa & Jeenah (2008) *African Journal of Psychiatry* 109.

¹¹⁸ McQuoid-Mason & Dhali 35-36.

¹¹⁹ Beauchamp & Childress 65; see also Preamble to the MHCA.

informed consent, it was shown that the acknowledgement of the right, even for mentally ill persons, preceded the enactment of the MHCA by several years. The ethical question of balancing users' rights and making an infringement on their right to informed consent and refusal was explored at the hand of professional ethical guidelines of the HPCSA and SASOP, as well as principles of biomedical ethics and other guiding principles. It was shown that the ethical question regarding infringements on users' rights in the psychiatric context, is often a more complicated one. While a straightforward answer about ethically justified infringements might not exist, ethical rules can provide useful guidance in this regard.

Chapter 3

Basic legal principles of informed consent

3.1 Introduction

The common law dictates that consent in terms of the Mental Health Care Act (the “MHCA”),¹ should be informed consent.² Consent to mental health care, treatment and rehabilitation services (“mental health treatment”) is a central theme to the MHCA and it is apparent that the legislature intended for mental health treatment, wherever possible, to be on a voluntary basis as is the case in other areas of medicine. Informed consent by a mentally competent individual should therefore be the usual legal excuse justifying the provision of treatment –³ in the psychiatric context and in other areas of medicine equally.⁴

This chapter will seek to establish a basic legal framework of common law consent, with specific reference to the doctrine of informed consent in medical law. The significance of the common law framework of informed consent lies in its application to the psychiatric context, particularly where specialised mental health legislation may be unclear or otherwise insufficient.

¹ 17 of 2002, as amended (the “MHCA”).

² Landman AA & Landman WJ (2014) *A practitioner’s guide to the Mental Health Care Act* 85. To interpret “consent” to mental health treatment as anything other than fully informed consent, would allow for unjustified infringements on person of the mental health care user (“user”).

³ Strauss SA ‘Bodily injury and the defence of consent’ (1964) *South African Law Journal* 179 at 185; Strauss SA (1984) *Doctor, patient and the law*, 2nd Ed 70; Carstens PA & Pearmain DL (2007) *Foundational principles of South African medical law* 875.

⁴ Part of the reason why informed consent is required, is because the doctor-patient relationship is usually based on a contract which presupposes *consensus ad idem* with regard to the medical intervention – Nöthling Slabbert, M (2014) ‘South Africa’ in Nys H (ed) (2014) *International Encyclopaedia of Laws: Medical Law* 1 at 70.

In establishing the general framework, the chapter will provide a basic overview of the common law defence of consent, on which the doctrine of informed consent is based. The discussion will centre on the origins of consent in *volenti non fit iniuria*, as well as selected aspects of the meaning, form and characteristics of consent and on the validity requirements of informed consent. The information requirement, the duty of disclosure will be explored in further detail. This aspect will relate to the standard of disclosure, the tests for material risk and limitations and extensions on the duty to disclose.

3.2 Consent and informed consent: general remarks

3.2.1 *Volenti non fit iniuria*

Consent has its basis in the common law defence of *volenti non fit iniuria* ("he who consents cannot be harmed"),⁵ which applies in both criminal and delictual matters.⁶ If proven successfully, consent will serve to justify conduct (such as medical treatment),⁷ which would otherwise have amounted to a wrongful invasion of the patient's physical integrity.⁸

⁵ Strauss SA (1963) *Aspekte van die begrip "Toestemming" in die strafreg en die deliktereg: 'n regsvergelende studie met besondere verwysing na die verweer vrywillige aanvaarding van risiko 7*; Boberg PQR (1984) *The law of delict Volume I, Aquilian liability* 724; Parmarand S 'The consenting plaintiff and the *boni mores*: the proper perspective' (1986) 3 *Journal of South African Law* 338 at 340; Schwär TG, Olivier JA & Loubser JD (1988) *The forensic ABC in medical practice: a practical guide* 8.

⁶ Strauss (1963) 5.

⁷ Van Oosten FFW *The doctrine of informed consent in medical law* (LLD thesis) UNISA (1989) 13; *R v Matomana* 1938 EDL 128 at 130-131 – adverse consequences which may arise in these circumstances would not be punishable; *S v Sikunyana and Others* 1961 (3) SA 549 (E); *S v D* 1963 (3) SA 263 (E); 10; *Castell v de Greef* 1994 (4) SA 408 (C) at 420-421 & 425-426; *C v Minister of Correctional Services* 1996 (4) SA 292 at 300G.

⁸ Strauss (1964) *South African Law Journal* 179; Boberg 724; Van Oosten (1989) LLD thesis 15; Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (LLD thesis) University of Pretoria (1996) 170; Carstens & Pearmain 875; Neethling J, Potgieter JM & Visser PJ *Law of Delict* (2010) 103; Nienaber A 'The regulation of informed consent to participation in clinical research by mentally ill persons in South Africa: An overview' (2010) 16 *South African Journal of Psychiatry* 118 at 120; *Castell* 1994 at 408C & 420H-I; *Stoffberg v Elliott* 1923

The *volenti* defence encompasses both consent to specific harmful conduct or injury (the narrower form) on one hand, and voluntary assumption of the risk of harm or injury (the wider form) on the other.⁹ The most obvious difference between the two forms is that unlike consent, voluntary assumption of risk involves no definite, imminent harm, but rather only the possibility or risk of harm occurring.¹⁰ Voluntary assumption of risk typically applies in the case of a participant in or a spectator of a dangerous sport.¹¹ While this does form part of the *volenti* defence, it is not what is meant by consent and informed consent in medical law.

3.2.2 The meaning, form and characteristics of consent

“Will” and “consent”

“Consent” is more than the “will” or “willingness” to accept harm.¹² Willingness refers only to a subjective state of mind,¹³ while consent both the subjective willingness to accept harm or conduct and the external manifestation thereof.¹⁴

CPD 148 at 149-50; *Lampert v Hefer* NO 1955 (2) SA 507 (A) at 508; *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T) at 718-22.

⁹ Strauss (1963) 40, 42, 70 & 74; Parmarand (1986) *Journal of South African Law* 340; Boberg 724; Van Oosten (1989) LLD thesis 14-15; *Lampert* at 508E; *Esterhuizen* at 719B; Van der Walt JC & Midgley JR (2005) *Principles of delict* 3rd Ed 140; Neethling *et al* 104. Furthermore, *volenti non fit iniuria* is distinct from contributory negligence, which pertains to the element of fault rather than wrongfulness or unlawfulness and involves active conduct that contributes to the causation of harm – see *Lampert* in general and particularly at 510D-G; *SANTAM Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A) at 764D, 778F. The *SANTAM*-case involved the question of voluntary assumption by the plaintiff (respondent), of the risks inherent in “dicing”. An apportionment of damages was made against the plaintiff (respondent) on the basis of contributory negligence. See also the discussion in Boberg 724-275 & 771, where it is averred that the *volenti* defence cannot be used for a “socially reprehensible” activity such as a “dicing” contest, and that the correct form of fault in this case was technically rather that of contributory intent than contributory negligence. Contributory negligence usually becomes contributory intent where fault takes the form of *dolus eventualis* instead of negligence. See also Carstens (1996) LLD thesis 171.

¹⁰ Strauss (1963) 28.

¹¹ Strauss (1963) 29.

¹² Strauss (1963) 11; Strauss SA & Strydom MJ (1967) *Die Suid-Afrikaanse geneeskundige reg* 186.

¹³ Strauss (1963) 11.

¹⁴ Strauss (1963) 11 & 14.

Whether actual consent was given will depend upon the facts of each particular matter.¹⁵

A declaration of the will

Consent is an external declaration of the will and in order to be legally valid, it must be made to manifest externally.¹⁶ The consent might not reflect the giver's true innermost thoughts, but logically, if the consent-giver has created the illusion of consent through his external conduct, this would be deemed true consent despite an unexpressed *reservatio mentalis*.¹⁷

Consent as juristic act

Consent to harm involves the abandonment of certain legal rights.¹⁸ Consent regulates the legal relationship between the consent-giver and the harm-doer and as such constitutes a juristic act.¹⁹ Juristic acts may be either unilateral or bilateral, but are unilateral in the case of consent to harm.²⁰

Form and manner of giving consent

As long as the general validity requirements are complied with, the form in which consent is given is of relatively minor importance.²¹ Consent may be either express

¹⁵ Strauss (1963) 11; Strauss & Strydom 186-187.

¹⁶ Strauss (1963) 71.

¹⁷ Strauss (1963) 23.

¹⁸ Van der Walt & Midgley 142, 144; Neethling *et al* 104-105.

¹⁹ Strauss (1963) 19, 71.

²⁰ Strauss (1963) 19.

²¹ No general rule exists regarding the form of consent. See par 12 of the Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: Seeking patients' informed consent: The ethical considerations* available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf (accessed 2 September 2014) (hereafter the "HPCSA *Guidelines on seeking patients' informed consent*"). Written consent may however, be required in terms of

or implied (tacit, or inferred from the giver's behaviour),²² and may be given either verbally or in writing.²³ Because written consent facilitates proof, it may benefit the doctor to obtain written consent be obtained for drastic or risky procedures, or procedures that are done with some purpose other than clinical care, such as medical research.²⁴ Logically the consent should be given prior to the offending conduct.²⁵

Revocation of consent

Because consent is a unilateral, external manifestation of the consent-giver's will,²⁶ consent may be unilaterally withdrawn by the consent-giver at any time before the procedure commences.²⁷ The revocation must be made to manifest externally.²⁸

While consent is not the same as a contract,²⁹ the two often go hand-in-hand,³⁰ and conceivably the revocation of consent could constitute a breach of contract – for instance where a patient who had previously signed a written contract later revokes his consent.³¹ The doctor may claim contractual damages in such an instance, if applicable, but may not administer treatment once consent has been revoked.³²

statute in certain instances (such as S4(c) of the Sterilisation Act 44 of 1998 or S6(a) of the Choice on Termination of Pregnancy Act 92 of 1996). See also Landman & Landman 88.

²² Strauss (1963) 24-25.

²³ Strauss (1963) 21; Schwär *et al* 8; Claassen NJB & Verschoor T (1992) *Medical negligence in South Africa* 59; Carstens (1996) LLD thesis 171; Neethling *et al* 105; Carstens & Pearmain 898; par 13.1 of the HPCSA *Guidelines on seeking patients' informed consent*; Nöthling Slabbert 71.

²⁴ Strauss (1984) 9; par 13.3 of the HPCSA *Guidelines on seeking patients' informed consent*.

²⁵ Van Oosten (1989) LLD thesis 18-19; Neethling *et al* 105; Landman & Landman 86.

²⁶ Strauss (1963) 14.

²⁷ Strauss & Strydom 207-208; Van der Walt & Midgley 144; Neethling *et al* 104-105; Landman & Landman 89.

²⁸ Strauss & Strydom 207; Claassen & Verschoor 75; Van der Walt & Midgley 144; Neethling *et al* 104.

²⁹ Strauss (1964) *South African Law Journal* 184.

³⁰ Strauss (1964) *South African Law Journal* 184.

³¹ Strauss & Strydom 208; Claassen & Verschoor 75.

³² Strauss & Strydom 208.

Refusal of consent

For practical purposes, someone with legal capacity to give informed consent is generally deemed capable of informed refusal.³³ Technically though, the requirements for valid informed refusal might not be exactly the same as for informed consent (arguably one could refuse an intervention without ever fully understanding its nature or implications).³⁴ A mentally competent person may refuse consent to treatment even if this is not in his best interests.³⁵

3.3 Requirements for valid informed consent

Valid consent will not exist simply because conduct was agreed to, and in order to constitute a legally valid defence certain requirements must be complied with.³⁶

3.3.1 Not *contra bonos mores*

Consent must accord with the *boni mores*, or the prevailing juristic notions of society.³⁷ It must, in other words, be recognised by law.³⁸ Consent will be invalid if it is *contra bonos mores*, even if all other validity requirements have been complied with.³⁹ One cannot validly consent to conduct which is in itself illegal or socially or

³³ Van Staden CW & Krüger C 'Incapacity to give informed consent owing to mental disorder' (2003) 29 *Journal of Medical Ethics* 41 at 43; Giesen 252; McQuoid-Mason & Dada 425.

³⁴ Van Staden CW & Krüger C 'Incapacity to give informed consent owing to mental disorder' (2003) 29 *Journal of Medical Ethics* 41 at 43; Giesen 252; McQuoid-Mason & Dada 425.

³⁵ Landman & Landman 89.

³⁶ Strauss (1963) 5.

³⁷ Strauss (1964) *South African Law Journal* 183; Strauss & Strydom 184-185; Parmarand (1986) *Journal of South African Law* 342; Van Oosten (1989) LLD thesis 17; Claassen & Verschoor 60; Van der Walt & Midgley 143-144; Neethling *et al* 108; Nöthling Slabbert 71-72; Landman & Landman 88.

³⁸ Van Oosten F 'The law and ethics of information and consent in medical research' (2000) 63 *Journal for Contemporary Roman-Dutch Law (THRHR)* 5 at 14.

³⁹ Parmarand (1986) *Journal of South African Law* 341.

morally reprehensible.⁴⁰ The *boni mores* may be seen as limiting the individual's freedom, or individualism embodied in the maxim of *volenti non fit iniuria*.⁴¹ Consent to sleep therapy in respect of any mental health care user is *contra bonos mores* because it is prohibited by the MHCA.⁴²

3.3.2 Clear and unequivocal

The law requires a consent which is clear, unequivocal and comprehensive enough so that the person agrees to accept the entirety of the conduct (such as a surgical operation) together with all its consequences.⁴³ Conduct by the harm-doer (the physician) must fall within the limits of the given consent in order to be considered justifiable.⁴⁴

3.3.3 Voluntary and free

Consent should be voluntary and free, and should be given without fear, threats, coercion, deceit, emotional manipulation, financial, social or moral pressure or influence.⁴⁵ Voluntariness may be diminished or obliterated by mental illness, including substance abuse.⁴⁶

⁴⁰ One cannot for instance, validly consent to a beating by an employer as punishment for a minor offence (*S v Collett* 1978 (3) SA 206 (RA); *R v McCoy* 1953 (2) SA 4 (SR)); to the driving-out of evil spirits via the infliction of serious bodily injuries (*Sikunyana* at 551D-E) or to one's own murder (*S v Robinson and Others* 1968 (1) SA 666 (A); *S v Nkwanyana* 2003 (1) SA 303 (W)).

⁴¹ Parmarand (1986) *Journal of South African Law* 338.

⁴² Reg 34 of the MHCA; Landman & Landman 88. The prohibition is likely due to the treatment modality's high mortality rate, frequent complications and uncertainty regarding effectiveness – Abrams R 'Miscellaneous organic therapies' in *Kaplan & Sadock's Comprehensive textbook of psychiatry-II 2nd Edition Volume 2* (eds Freedman AM, Kaplan HI & Sadock BJ) (1975) 1987 at 1988.

⁴³ Strauss (1984) 8; Van Oosten (1989) LLD thesis 18-19; *Castell* 1994 at 425I; Claassen & Verchoor 75; Van der Walt & Midgley 142, 144; McQuoid-Mason D & Dada M (2011) *A – Z of medical law* 93; Neethling *et al* 105; Nöthling Slabbert 84.

⁴⁴ Van Oosten (1989) LLD thesis 19; Van der Walt & Midgley 142; Neethling *et al* 108.

⁴⁵ Strauss & Strydom 206-207; Parmarand (1986) *Journal of South African Law* 340, 341; Van Oosten (1989) LLD thesis 17; Carstens (1996) LLD thesis 171; Van der Walt & Midgley 142;

3.3.4 Mental capacity

Valid consent must be obtained from someone with both legal and factual capacity to give it.⁴⁷ The general legal test of mental capacity relates to the person's ability to perform a legal act, such as consenting to treatment.⁴⁸ There are different legal criteria for the capacity to perform different legal acts, whether to conclude a contract, make a will or consent to medical treatment.⁴⁹ It relates to whether the person is able to understand the nature of what he is doing, and to appreciate the consequences thereof.⁵⁰

While the same test and standard of capacity should apply to mentally ill persons, mental capacity in the context of consent could be particularly problematic for mental health care practitioners. As such, the practitioner should be careful to ensure that the mentally ill person does have the necessary capacity to make decisions about mental health care and if he does not, should take steps to obtain consent from an appropriate surrogate.⁵¹ A person may be rendered legally incapable of making treatment-related decisions by a variety of possible factors,

Neethling *et al* 106; McQuoid-Mason & Dada 93; Zabow T & Kaliski S 'Ethical considerations' in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 357 at 371; Nöthling Slabbert 84; Landman & Landman 88.

⁴⁶ Voluntariness means freedom from control or influence by individuals and also freedom from "control" or "influence" by mental conditions – Beauchamp & Childress 93.

⁴⁷ Strauss (1984) 4; Carstens (1996) LLD thesis 171 (where reference is made to the Afrikaans *wilsvermoë*); Van Oosten (2000) *THRHR* 14-15; Neethling *et al* 106.

⁴⁸ Van der Walt & Midgley 144. The ability to consent also depends on considerations such as the rights and interests affected, the degree of potential harm and the complexity of treatment.

⁴⁹ Zabow T 'Competence and decision-making: Ethics and clinical psychiatric practice' (2008) 1 *South African Journal of Bioethics and Law* 61 at 61.

⁵⁰ Van Oosten (1989) LLD thesis 17; McQuoid-Mason & Dada 93 – capacity does not necessarily imply full capacity to act, but at least that the person is "intellectually mature enough to appreciate the implications of his acts". See also *S v Marx* 1962 (1) SA 848 (N) 854 at 854C-D, which demonstrates that young age and the associated lack of capacity to consent may exclude the *volenti* defence.

⁵¹ Strauss (1984) 4; Carstens (1996) LLD thesis 171; Claassen & Verschoor 62; Dada MA & McQuoid-Mason DJ (eds) (2001) *Introduction to medico-legal practice* 111; Neethling *et al* 105. An appropriate surrogate, such as a curator of a mentally ill person, or a proxy consent-giver in terms of S 7(1) and 8 of the National Health Act 61 of 2003 (hereafter the "NHA") may consent on an incapacitated person's behalf, but as a rule consent to medical treatment is obtained from the patient personally, provided that he is of "sound and sober senses".

including not only mental illness but also drugs, medication, unconsciousness and shock.⁵²

3.3.5 Knowledge, appreciation and actual consent

[K]nowledge, appreciation, consent... are the essential elements for the defence of *volenti non fit iniuria*.⁵³

Legally valid consent requires knowledge, appreciation and acquiescence on the part of the patient.⁵⁴ Knowledge of the nature and extent of harm or risk is requisite for valid consent.⁵⁵ The patient should know what he is consenting to, including the relevant, material facts pertaining to the potentially harmful act.⁵⁶ If the patient has not been warned about the serious and typical risks involved in medical treatment, then he cannot validly consent thereto, because in his ignorance he would lack the required knowledge and awareness.⁵⁷ This implies that the patient must subjectively foresee the specific harm or risk.⁵⁸ The patient may subjectively foresee some of

⁵² Strauss (1984) 4; Carstens & Pearmain 248.

⁵³ Innes CJ in *Waring & Gillow Ltd v Sherborne* 1904 TS 340 at 344. See also discussion of the matter in Boberg 752-753 as well as par 4.1.1-4.1.4 of the HPCSA *Guidelines on seeking patients' informed consent*.

⁵⁴ Nöthling Slabbert 71. Acquiescence means a willingness on the part of the patient to submit to conduct, such as a medical procedure. It is defined in the *Concise Oxford English Dictionary* as "accepting or consenting to something without protest" – Soanes C & Stevenson A (eds) (2004) *Concise Oxford English Dictionary 11th Edition* 11 – the word is derived from the Latin "*acquiescere*", from "*ad-*" ("to") + "*quiescere*" ("to rest"). The meaning of the word is also apparent from the Afrikaans "*berusting*".

⁵⁵ Strauss & Strydom 209; Parmarand (1986) *Journal of South African Law* 340, 341; Van Oosten (1989) LLD thesis 18; Carstens (1996) LLD thesis 171; *Castell* 1994 at 425H where it is determined that the patient "...must have had knowledge and been aware of the nature and extent of the harm or risk"; Neethling *et al* 106; *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 173B.

⁵⁶ Carstens (1996) LLD thesis 171; Van der Walt & Midgley 141; Neethling *et al* 106; McQuoid-Mason & Dada 93.

⁵⁷ *Rompel v Botha* 1953 (T) (unreported), as discussed in Strauss & Strydom and in Boberg 748; Carstens & Pearmain 885.

⁵⁸ Van der Walt & Midgley 143.

the risks and not others, in which case it is possible that he could be *volens* only in respect of those risks which he did foresee.⁵⁹

Knowledge or perception of the dangers inherent in treatment is not sufficient to establish consent, and except for knowledge and awareness, the consenting party must also have a subjective understanding or appreciation of the nature and extent of the harm or risk inherent in treatment.⁶⁰ Whether consent was given with appreciation of harm or risk, does not relate to the question of what the patient ought to have understood.⁶¹ Rather, the test is subjective in considering what the patient actually did understand.⁶² Understanding, at the very least, involves a grasp of the central facts about the nature and consequences of an intended action.⁶³

Problems with information processing (an inherent danger in mental illness and – disability), non-acceptance of essential facts or false beliefs would influence the validity of consent.⁶⁴ Valid consent would be out of the question if treatment was agreed to in the belief that it was harmless, since “consent” in such a case would have been given without the necessary knowledge and appreciation.⁶⁵ The patient’s ignorance would render his “consent” invalid.⁶⁶

Effective consent requires more than knowledge and appreciation alone – in the words of Ogilvie Thompson CJ in *SANTAM*, the maxim is, after all, “*volenti non fit*

⁵⁹ Van der Walt & Midgley 143.

⁶⁰ Parmarand (1986) *Journal of South African Law* 340, 341; Van Oosten 1989 24; Neethling et al 107; McQuoid-Mason & Dada 93; Van Oosten (2000) *THRHR* 23; *Castell* at 425H; *Esterhuizen* 1957 3 SA 710 (T) 712, 719C-D, where it is stated that the patient needs to not only have perceived but also to have fully appreciated the risks; *SANTAM*-case. McQuoid-Mason & Dada 93. Van Oosten (2000) *THRHR* 23. Van der Walt & Midgley 142; *Lampert- & Castell* 1994 cases overall.

⁶¹ As suggested in *Lymbery* at 240.

⁶² Strauss & Strydom 214; Van Oosten (2000) *THRHR* 23.

⁶³ Beauchamp & Childress 88.

⁶⁴ Beauchamp & Childress 90-92.

⁶⁵ *Esterhuizen* at 719-721. See also the case discussion in Boberg 747-752. The plaintiff in *Esterhuizen* had simply been told by the defendant “not to worry” about the deep X-ray treatment that would later result in severe disfigurement, and certainly did not perceive it as hazardous – Boberg 747. *Rompel* case, as discussed in Boberg 748-749.

⁶⁶ Strauss & Strydom 211.

iniuria and not *scienti non fit iniuria*'.⁶⁷ The law requires actual, active and subjective consent on the part of the consent-giver.⁶⁸ As already alluded to in the afore-going paragraphs, consent is an active declaration of the will which must be made apparent externally. This aspect also relates to the requirement of an actual and subjective consent.⁶⁹

3.3.6 Information

The doctrine of informed consent in medicine requires that the doctor must obtain not only a patient's consent to a medical treatment or procedure, but his informed consent.⁷⁰ This may be considered a higher standard of consent than is the case for ordinary common law consent.⁷¹

Information and validity of consent

Information is not strictly required in order for *volenti non fit iniuria* to operate as a valid defence in common law.⁷² But valid consent requires both full knowledge and understanding/appreciation on the part of the patient,⁷³ which in the context of medicine is often dependent on appropriate information.⁷⁴ The disclosure of

⁶⁷ *SANTAM*-case at 779C; Van der Walt & Midgley 142.

⁶⁸ *Waring & Gillow* at 344; Strauss (1963) 17; Van Oosten (1989) LLD thesis 18; Neethling *et al* 107; McQuoid-Mason & Dada 93; Van der Walt & Midgley 142; *Castell* 1994 at 425H-J; S8(2)(b) of the NHA.

⁶⁹ Landman & Landman 88.

⁷⁰ Van Oosten (1989) LLD thesis 18, 20-22; Van Oosten (2000) *THRHR* 23; Carstens & Pearmain 882; Neethling *et al* 106-107; Dada & McQuoid-Mason 111; *Castell* 1994 at 420I-421D & 425C-426G; *C v Minister of Correctional Services* at 300; Landman & Landman 85-87.

⁷¹ Kim SYH (2010) *Evaluation of capacity to consent to treatment and research* 5-7 & 11, where "informed consent" is differentiated from "simple consent".

⁷² Van Oosten (1989) LLD thesis 24.

⁷³ *Esterhuizen* at 719D-E (where *Rompel v Botha* 1953 (T), unreported, is discussed in relation to the same issue); *Lymbery* at 240; *C v Minister of Correctional Services* at 300-301; Parmarand (1986) *Journal of South African Law* 340, 341; Van Oosten (2000) *THRHR* 23.

⁷⁴ Strauss & Strydom 212; Van Oosten (1989) LLD thesis 20; Van Oosten (2000) *THRHR* 23.

adequate (if not full)⁷⁵ information is therefore both a legal- and ethical requirement for informed consent.⁷⁶

From a practical viewpoint, the prior disclosure of information is not invariably needed in order for knowledge and appreciation to exist. In most “everyday transactions”, where the relationship between parties is more or less on equal footing, the consent-giver is already in possession of the information he needs and will not need to be counselled again in advance.⁷⁷ Conversely, in “professional transactions”, typically in medicine, the distribution of power between the parties is usually unequal, with one party being an expert and the other a layperson.⁷⁸ In the case of a doctor and patient, it is usually impossible for the patient as medical layperson to have the knowledge and appreciation needed for valid informed consent to medical treatment, without having been properly counselled beforehand.⁷⁹

In professional situations information will therefore be necessary for the patient to acquire knowledge of the nature and extent of the harm or risk involved in the proposed treatment.⁸⁰ Knowledge, in turn, will enable the patient to understand and appreciate of the nature and extent of the harm or risk.⁸¹ In this way, information

⁷⁵ It might not be realistic to disclose absolutely everything about a treatment or operation to a patient – Veatch RM (2003) *The basics of bioethics 2nd Ed* 77.

⁷⁶ Zabow & Kaliski 372. Disclosure ensures patient autonomy and therapy (the two purposes which relate to the two forms of disclosure, namely “self-determination disclosure” and “therapeutic disclosure”) – Van Oosten (1993) *Medicine and Law* 655, 656; Van Oosten (2000) *THRHR* 24-25.

⁷⁷ Van Oosten (1989) LLD thesis 20-21 - an experienced boxer would already have knowledge and appreciation of the dangers inherent in the sport without needing to be counselled prior to every match, and the opponent who injures him during the match could rely on *volenti non fit iniuria* in the event of a criminal or delictual claim even if the risks were never discussed beforehand.

⁷⁸ Van Oosten (1989) LLD thesis 22; Nöthling Slabbert 77.

⁷⁹ Van Oosten (1989) LLD thesis 22; Van Oosten (2000) *THRHR* 23.

⁸⁰ Van Oosten (1989) LLD thesis 23.

⁸¹ The opposite does not hold true – while one cannot form appreciation without knowledge, it is possible to have knowledge of something without appreciation of its nature and consequences. See van Oosten (1989) LLD thesis 23; Neethling *et al* 105.

becomes the basis upon which knowledge and appreciation are built, and becomes an integral part of valid, informed consent in medicine.⁸²

3.4 Standard of disclosure: how much should the doctor tell?

A wise man depends upon his friends for information and upon himself for decisions...⁸³

Deciding exactly how much information to disclose in order to meet legal and ethical obligations can be a somewhat challenging.⁸⁴ As outlined in *Richter and Another v Estate Hammann*:

A doctor whose advice is sought about an operation to which certain dangers are attached... is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient's interests to have it.⁸⁵

The patient should be informed of the nature and consequences of the treatment.⁸⁶
The doctor must explain in simple terms, basic aspects of treatment such as the

⁸² Van Oosten (1989) LLD thesis 23-24; Carstens & Pearmain 879; Van Oosten (2000) *THRHR* 23. Also *Rompel* case, as discussed in *Esterhuizen* at 719C-F.

⁸³ Herbert F (1980) *Direct descent* 54.

⁸⁴ The question regarding the duty and extent of disclosure exposes the conflict between considerations of the patient's well-being and will, and by extension between principles of beneficence and patient autonomy - Giesen D 'From paternalism to self-determination to shared decision making' (1988) *Acta Juridica* 107 at 109.

⁸⁵ 1976 (3) SA 226 (C) at 226B-C. In this matter, the plaintiff had suffered incontinence, loss of sexual feeling and paralysis in the right leg and foot after having undergone a phenol block at the hands of an experienced neuro-surgeon, one Dr Hammann. The said complications were so rare that the medical experts regarded them as immaterial and felt that Dr Hammann had not erred in failing to warn the plaintiff of these risks. The court accepted this view. See also discussion in Strauss (1984) 323-324.

⁸⁶ Strauss & Strydom 213. Disclosure of a diagnosis is a separate issue from disclosure of the nature and risks of medical treatment – Strauss (1984) 13-15; also Nöthling Slabbert 82 for a more detailed discussion.

scope, importance, risks, benefits, prognosis and alternatives of the proposed intervention,⁸⁷ so that the patient has enough information to weigh up their options and make an intelligent decision about whether or not he wants to undergo the proposed intervention.⁸⁸

Section 7(3) read with section 6 of the National Health Act 61 of 2003 provide that, as a guideline the patient should be informed of:

- his health status, unless disclosure would likely not be in his best interest;
- the range of generally available diagnostic- and treatment options;
- the benefits, risks, costs and consequences usually associated with each option;
and
- the right to refuse treatment, and the implications, risks, obligations if this route is chosen.

The level of disclosure will depend on the specific situation, and other factors which might be taken into account include the nature of the illness; nature and complexity of the procedure; alternative treatments; the urgency of the proposed treatment; the potential adverse effects; the degree of risk or danger involved; the likelihood of complications; the doctor's level of expertise and experience; the available

⁸⁷ Van Oosten (1995) *De Jure* 170; Van Oosten (2000) *THRHR* 25; *Lymbery* at 240, particularly 240C.

⁸⁸ Strauss (1984) 7; Giesen D (1988) *International medical malpractice law: A comparative law study of civil liability arising from medical care* 258; Van der Walt & Midgley 146.

personnel, equipment and how specialised the hospital or clinic is and the patient's own wishes and professional, social and personal life.⁸⁹

Information should be given about all serious and typical risks of treatment.⁹⁰ Information disclosed should relate to the specific harms or risks inherent in treatment.⁹¹ It is not, however, necessary to disclose in meticulous detail every possible risk or complication which may arise,⁹² or to disclose other information that could only cause the patient undue distress or scare them into refusing necessary medical treatment.⁹³ The doctor who over-informs the patient to the latter's detriment might actually run the risk of delictual liability for doing so.⁹⁴

3.4.1 Tests of disclosure and "material risk"

The patient should be informed of inevitable consequences related to an operation or treatment, such as a hysterectomy which would inevitably lead to infertility.⁹⁵ The question regarding disclosure becomes more complex where a consequence is not inevitable, but there is a risk of complications occurring.

Because there are so many factors that can influence the standard of disclosure, the argument that no single precedent or test of disclosure should be strictly applied is

⁸⁹ Van Oosten (1995) *De Jure* 170-171; par 3.1.1 of the HPCSA *Guidelines on seeking patients' informed consent*.

⁹⁰ In *Richter* for example, there was a risk of serious complications inherent in the phenol block administered by the neurosurgeon, but the complication was "extremely uncommon" rather than typical, and so the defendant was found not liable for having failed to inform the plaintiff thereof. See *Boberg* 751.

⁹¹ Van der Walt & Midgley 143.

⁹² Van Oosten (1995) *De Jure* 170; *Richter* at 230F-G, 233B-D; *Lymbery* at 236 & 240: "There is no necessity to point out meticulously all the complications that may arise".

⁹³ Van Oosten (1995) *De Jure* 171; *SA Medical & Dental Council v McLoughlin* 1948 (2) SA 355 (A) at 366: "It may sometimes even be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him..."; *Richter* at 232G-H; *Castell v de Greef* 1993 (3) SA 501 (C) at 518G-H.

⁹⁴ *Strauss* (1984) 8.

⁹⁵ *Strauss* (1984) 7.

persuasive.⁹⁶ Conflicting judgements have been delivered regarding which test should be used to determine whether a risk is “material” or not.⁹⁷ In this regard two schools of thought can be distinguished relating to disclosure of risk and the determination of whether a risk is material, namely the reasonable doctor approach, and the patient-centred approach.⁹⁸

The reasonable doctor approach (the medical opinion approach)⁹⁹ as applied in the *Richter* case, is derived from the English case of *Bolam v Friern Hospital Management Committee*,¹⁰⁰ as followed in *Sidaway v Bethlem Royal Hospital Governors and others*.¹⁰¹ In accordance with this test, the question of whether a risk is material depends on medical opinion or the professional standard regarding what should be disclosed.¹⁰² Whether a patient should be warned about a risk depends solely on whether a respected body of medical opinion exists to support giving the warning. A patient could be denied information about risks inherent in treatment even if he wants the information and asks for it, because medical opinion alone determines whether or not the risk should be disclosed.¹⁰³ A risk could be

⁹⁶ Wilson M ‘When is a risk of medical treatment material?’ (2006) *De Rebus* 22 at 22.

⁹⁷ The main schools of thought are in favour of a physician-centred approach on one hand, and a patient-centred approach on the other. See *Richter* at 232G-H; *Castell* 1994 at 426F; Beauchamp & Childress 82. See also Giesen (1988) *Acta Juridica* 109-110, where the author suggests that the physician-centred approach, in accordance with traditional medical ethics, gives precedence to considerations of the patient’s well-being (*salus*) over that of the patient’s will (*voluntas*). The doctor-centred approach essentially reduces the standard of disclosure to a question of clinical judgement.

⁹⁸ Beauchamp & Childress 81-83. The patient-centred approach is sometimes viewed as two separate tests, i.e. the reasonable person standard and the subjective test. In South African law these are combined into a patient-centred test as will become apparent over the course of the discussion.

⁹⁹ Wilson (2006) *De Rebus* 23.

¹⁰⁰ [1957] 2 All ER 118. In *Bolam*, the practitioner’s conduct including the decision about whether to warn, is measured at the hand of “a practice of competent respected professional opinion” (at 121H) and “good medical practice” (at 122H). This case involved a voluntary psychiatric patient who sustained physical injuries whilst undergoing electroconvulsive therapy (“ECT”) at a psychiatric institution.

¹⁰¹ [1985] 1 All ER 643.

¹⁰² Beauchamp & Childress 81; Wilson (2006) *De Rebus* 23, 25.

¹⁰³ Wilson (2006) *De Rebus* 24.

considered “not material” in terms of the *Bolam* test if its chances of occurring are too statistically remote.¹⁰⁴ This approach is not followed in many jurisdictions.¹⁰⁵

A subjective reasonable patient test is followed in the Australian judgement of *Rogers v Whitaker*,¹⁰⁶ where the materiality of a risk is determined at the hand of whether a reasonable patient would have wanted to be informed of the particular risk.¹⁰⁷ Contrary to the medical opinion-approach, the court in *Rogers* finds that the mere fact that there is a responsible body of medical opinion to favour non-disclosure of a risk does not preclude a finding of negligence on the basis of non-disclosure.

In the matter of *Castell*,¹⁰⁸ Ackermann J formulates the test of disclosure with reference to the *Rogers* case, rejecting the standard of the reasonable doctor in favour of a subjective patient-centred approach to disclosure.¹⁰⁹ The test of disclosure in *Castell* deems a risk to be “material” if:¹¹⁰

- the reasonable patient would, if warned of the risk, be likely to attach significance to it;¹¹¹ or
- the doctor knows or reasonably ought to know that the specific patient, if warned of the risk, would be likely to attach significance to it.¹¹²

¹⁰⁴ Wilson (2006) *De Rebus* 23.

¹⁰⁵ Wilson (2006) *De Rebus* 23.

¹⁰⁶ (1993) 175 CLR 479.

¹⁰⁷ In this matter, the plaintiff instituted action after having been left blind in her one eye due to complications of eye surgery, a rare complication about which the defendant had allegedly failed to warn her. See also Wilson (2006) *De Rebus* 23.

¹⁰⁸ *Castell* 1994.

¹⁰⁹ 1994 at 426F-H.

¹¹⁰ *Castell* 1994 at 426F. The test for whether a risk is “material” is also cited in par 3.3.2 of the HPCSA *Guidelines on seeking patients’ informed consent*.

¹¹¹ This might also be viewed separately as a “reasonable person” standard – Beauchamp & Childress 82-83.

¹¹² *Castell* 1994 at 426F-G. The patient-centred test was discussed again in the recent judgement of *Sibisi NO v Maitin* (311/13) [2014] ZASCA 156 1 October 2014 15 at par [51]. The court avoided

Whether risks are typical, common or inherent in a procedure is a matter for scientific expert evidence, which the court should evaluate at the hand of accepted guidelines.¹¹³ The patient-centred test takes medical opinion, statistical probabilities and precedent into account, but does not rely exclusively on any of these factors.¹¹⁴ Unlike the physician-centred approach, this test allows that a very negligible risk (such as a 0.007% risk of a complication occurring) may be material as long as it meets the criteria in the *Castell*-test.

The test for material risk in *Castell* accords with constitutional, common law and ethical principles locally as well as international judicial standards requiring respect for autonomy and the right to self-determination and rejecting medical paternalism.¹¹⁵

The test acknowledges the patient's right to independent choice, and is flexible and adaptable to changing circumstances and societies.¹¹⁶ A test like this which acknowledges the individual freedoms that demand informed consent and disclosure is not only justified, but necessary.¹¹⁷ An approach which fails to make this

challenging the correctness of *Castell* 1994. The subjective test, which takes into account the individual person rather than the reasonable person, is sometimes viewed as a separate test – Beauchamp & Childress 83.

¹¹³ The guidelines were established in *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) (in particular at 1201E-H), and followed in *Louwrens v Oldwage* 2006 (2) SA 161 (SCA) at 175E-H. See also Carstens & Pearmain 885.

¹¹⁴ Wilson (2006) *De Rebus* 24.

¹¹⁵ *Castell* 1994 at 408 & 426. The idea of a physician-centred approach (or the “reasonable doctor” test) to disclosure of information has had little support in South African law, both before the *Castell* matter and since – *Castell* 1994 at 408G-H. The “reasonable doctor” test for disclosure was followed in *Castell* 1993 at 517H – 518B; *Richter* at 232H and is mentioned *obiter* in *SA Medical & Dental Council* at 366.

¹¹⁶ Wilson (2006) *De Rebus* 24.

¹¹⁷ Van Oosten (1995) *De Jure* 173.

acknowledgement would be unacceptable for failing to preserve the patient's right to bodily integrity and autonomous choices.¹¹⁸

The judgement in *Castell*, including the test for material risk, serves as authority for the fact that South African courts favour patient autonomy over medical paternalism, and the judgement has not yet been overruled.¹¹⁹

The most recent reported judgement on the issue of material risk, in the *Louwrens*-matter, the court is indecisive about which test should be followed.¹²⁰ It makes reference to the test in *Castell*, but does not openly reject it.¹²¹ It approves the doctor-centred test followed in *Richter*, but does not apply it either.¹²²

Since there has been no clear-cut decision as to which test should be applied, courts are at liberty to apply any test for material risk at their discretion.¹²³ It is submitted that the patient-orientated approach is the only feasible option in the present culture of human rights, and this approach should enjoy preference in South African courts.

3.4.2 Limitations and extensions of the duty to disclose

The physician's duty to disclose information will be limited when the patient already has the relevant information;¹²⁴ does not wish to be informed and has (either

¹¹⁸ *Castell* 1994 at 421C-D.

¹¹⁹ It is later applied *McDonald v Wroe* 2006 JDR 0166 (unreported) at par [7]. In *Louwrens v Oldwage* the test in *Castell* 1994 is not applied, but not rejected as being incorrect either. See Carstens & Pearmain 887.

¹²⁰ Wilson (2006) *De Rebus* 24. The court *a quo*, in *Oldwage v Dr Louwrens* (2004) JDR 0023 (C) at 45-50, applied the test in *Castell* 1994, but this was overturned in the subsequent ruling of the Supreme Court of Appeal.

¹²¹ *Louwrens* at 173; Wilson (2006) *De Rebus* 25.

¹²² *Louwrens* at 174-175; Wilson (2006) *De Rebus* 25.

¹²³ Wilson (2006) *De Rebus* 25.

¹²⁴ Van Oosten *De Jure* 172; *Castell* 1993 at 520C-D: "...a reasonably intelligent person, such as the plaintiff, would hardly have to be told...". Also Nöthling Slabbert 82.

expressly or implicitly) waived his right to information;¹²⁵ when it is physically impossible to disclose information;¹²⁶ or when the therapeutic privilege (“contra-indication”) applies, meaning that the harm caused to the patient by disclosure of information would be greater than the harm caused by non-disclosure.¹²⁷

Since the therapeutic privilege involves the paternalistic withholding of information at the expense of patient autonomy,¹²⁸ the extent of its application following the *Castell* judgements is questionable.¹²⁹ In the light of constitutional and ethical considerations, an infringement upon the autonomy of mentally ill persons based on therapeutic privilege would probably only be justified in truly exceptional and compelling circumstances.¹³⁰

It is conceivable that “novel instances” of nondisclosure could arise, and in such situations the common law should be developed according to the CRSA and in accordance with the values, spirit and purport of the CRSA.¹³¹

The physician will sometimes be obliged to disclose more information than usual, for instance if the patient asks more questions, even if the added disclosure might be

¹²⁵ Van Oosten (1995) *De Jure* 172; Claassen & Verschoor 69; Nöthling Slabbert 83.

¹²⁶ Van Oosten (1995) *De Jure* 172; *Richter* at 232G-H; Nöthling Slabbert 83.

¹²⁷ Van Oosten (1995) *De Jure* 172; Beauchamp & Childress 84, 179. The exception would typically apply where a patient was in a frail state of mind and disclosure would probably only hinder their recovery – *Castell* 1994 at 426H read with 418D-E; Strauss & Strydom 219. The therapeutic privilege is reflected in statute, at S6(1)(a) & S8(3) of the NHA and in S30 of the Promotion of Access to Information Act 2 of 2000 (“PAIA”). S30 deals with access to health- and medical records and specifically with the disclosure of health-related information which may be considered detrimental. Par 3.3.1 of the HPCSA *Guidelines on seeking patients’ informed consent* state that the doctor may withhold information necessary for decision-making if it would cause the patient “serious harm” or (at par. 3.3.4) may justifiably fail to provide information if disclosure would be “contrary to the best interests” of the patient. See also Carstens & Pearmain 887-888. Also Claassen & Verschoor 70.

¹²⁸ For this reason the therapeutic privilege accords with Hippocratic ethics, which teach that the physician should only impart on the patient information which would (in the doctor’s opinion) benefit the patient. This is in contrast to the Kantian view which demands truth-telling out of respect for the individual’s autonomy, and does not condone the deception of patients for any purpose. See Veatch 81-82.

¹²⁹ Van Oosten (1995) *De Jure* 174; also *Castell* 1994 at 426E.

¹³⁰ S9, 12, 27 & 36 of the CRSA; also Carstens & Pearmain 887-888.

¹³¹ Nöthling Slabbert 83.

considered harmful;¹³² or if the patient refuses treatment, in which case the importance of the treatment must be impressed upon them by providing further relevant information.¹³³

3.5 Conclusion

This chapter has sought to establish a framework for informed consent in medicine to be applied *mutatis mutandis* to the context of informed consent by psychiatric patients. The framework is of particular relevance where insufficient legislative provisions exist to govern informed consent by mentally ill persons, and the common law should be relied upon for purposes of interpretation and clarification of “consent”.

An exposition was given of consent in terms of its relation to the defence of *volenti non fit iniuria*, of which it forms part. Common law consent was explored with reference to its meaning, form and characteristics, and validity requirements for informed consent. It was demonstrated that information is crucial to the validity of consent, because it could influence the patient’s ability to acquire an adequate knowledge and understanding of the risks inherent in medical treatment. An absence of information could therefore completely undermine the validity of consent.

The duty to disclose was discussed. It was illustrated the extent of disclosure is dependent upon several factors, including the test one applies to interpret the meaning of what constitutes a “material risk”. The various tests for disclosure and material risk were discussed and it was submitted that the subjective patient-centred test for material risk is the proper approach to be followed. Reference was made to limitations and extensions on the duty to disclose.

¹³² Van Oosten (1995) *De Jure* 171; Carstens & Pearmain 887; Nöthling Slabbert 82.

¹³³ Van Oosten (1995) *De Jure* 172; Carstens & Pearmain 887.

Chapter 4

Justifiable treatment-provision in the absence of informed consent

4.1 Introduction

It is not always possible to obtain informed consent from a patient prior to administering medical treatment. In these instances the practitioner would have to rely on another excuse to justify the provision of treatment.¹ In the context of mental health care, treatment and rehabilitation (“mental health treatment”) provided in the absence of informed consent, the provisions of the Mental Health Care Act (the “MHCA”)² would usually serve as the justification for mental health treatment-provision. However, should circumstances necessitate and the MHCA cannot be complied with, the common law grounds of justification should remain available to the mental health care practitioner.

The aim of this chapter is to provide a brief summary of the circumstances in which treatment-provision in the absence of informed consent would be justified. This will be done with reference to the alternative common law defences against liability, in context of the constitution (the “CRSA”),³ and the ethical justifiability of autonomy infringements. The chapter further aims to demonstrate the grounds on which liability may be incurred if treatment is provided in the absence of any justification.

¹ *Stoffberg v Elliott* 1923 CPD 148 at 150; *Ex parte Dixie* 1950 4 SA 748 (W) at 751C-D; *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T) at 719C-E (where the matter of *Rompel v Botha* TPD, 15th April, 1953, unreported is referred to); *Castell v de Greef* 1994 (4) SA 408 (C) at 417G-I.

² 17 of 2002, as amended (the “MHCA”).

³ The Constitution of the Republic of South Africa, 1996 (the “CRSA”).

The chapter will discuss grounds of justification, firstly with reference to their place among the multiple defences available to the practitioner faced with potential liability on the basis of malpractice.

Grounds of justification will then be discussed at the hand of its operation as a defence which nullifies the wrongfulness (unlawfulness) of a delict or crime which is nullified by a ground of justification. In this regard reference will be made to the *boni mores* standard of wrongfulness.

Specific grounds of justification which may be relied upon in the absence of informed consent will then be discussed, including emergencies, court order, statutory authority and constitutional grounds of justification.

The chapter will conclude with a short discussion of the physician's liability for providing medical treatment in the absence of informed consent or any other ground of justification. The question regarding the proper ground of liability for failure to obtain informed consent will be explored at the hand of reported case law. Reference will also be made to the burden of proof for absence of informed consent, with reference to recently reported case law.

4.2 Grounds of justification and multiple defences against liability

It is not always possible to obtain prior consent from a patient, whether due to age, delirium or some other factor.⁴ In such cases medical intervention may be justified on grounds other than consent.⁵ Grounds of justification as they exist in common

⁴ Strauss SA 'Bodily injury and the defence of consent' (1964) *South African Law Journal* 179 at 186.

⁵ Keeping in mind that the doctor may not intervene against the will of a mentally competent patient – Strauss (1964) *South African Law Journal* 185-186.

law are often reflected in constitutional- and legislative provisions and in ethical principles.

The defendant (doctor) who is faced with possible civil or criminal liability may invoke multiple defences.⁶ This results partly from the fact that, while the plaintiff (the patient), or the state, bears the onus of proving all five elements of a delict or crime in order to prove their case,⁷ the physician merely needs to strike down one of the elements in order to escape liability.⁸

Specific defences relate to the five elements of a crime or delict, and the defendant could plead the absence of any of the elements based on a variety of possible defences.⁹

4.3 The nullification of wrongfulness

4.3.1 The element of wrongfulness

In principle any interference with the person of another in the absence of their informed consent or another ground of justification, is *prima facie* wrongful – whether the interference takes the form of medical intervention or otherwise.¹⁰

The grounds of justification are defences which operate by nullifying the element of wrongfulness.¹¹ For this reason, some authors have opined that they are nothing other than by-products of the reasonableness standard (the *boni mores* standard).¹²

⁶ Carstens PA & Pearmain DL (2007) *Foundational principles of South African medical law* 872.

⁷ Carstens & Pearmain 873. The plaintiff's onus of proof is on a balance of probabilities, and that of the state beyond reasonable doubt.

⁸ Carstens & Pearmain 872.

⁹ Carstens & Pearmain 872-873.

¹⁰ Strauss SA & Strydom MJ (1967) *Die Suid-Afrikaanse geneeskundige reg* 179; *Castell* 1994 at 420H-I.

4.3.2 The *boni mores* standard

The wrongfulness, or justifiability, of conduct involves evaluation thereof against the standard of reasonableness, or the prevailing *boni mores* or legal convictions of society.¹³ The *boni mores* standard applies in both civil- and criminal cases.¹⁴

Reasonableness is not a static criterion, but depends greatly on the changing values of changing societies.¹⁵ Whether conduct was reasonable would depend on contextual factors as the parties' motives; the extent and foreseeability of harm; the nature of the affected object or right; the existence (or not) of a special relationship between the parties, and, especially in South African context, the principles and values embodied in the CRSA.¹⁶

In an era where the *boni mores* are constitutionally informed,¹⁷ courts must adapt and extend the grounds of justification as necessary to keep up with society's

¹¹ Van der Walt JC & Midgley JR (2005) *Principles of delict 3rd Ed* 125. Grounds of justification are also listed and discussed in Strauss (1964) *South African Law Journal* 186; Van Oosten FFW *The doctrine of informed consent in medical law* (unpublished LLD thesis) UNISA (1989) 13; Van der Walt & Midgley 71, 126; Claassen NJB & Verschoor T (1992) *Medical negligence in South Africa* 75-78; Carstens & Pearmain 873. See Carstens & Pearmain 875 – 941 for a comprehensive discussion of the grounds of justification.

¹² Van der Walt & Midgley 71.

¹³ Strauss (1964) *South African Law Journal* 183; Van der Walt & Midgley 69-70. While public policy and the moral notions of society may overlap with society's legal convictions, the distinction remains between moral or ethical duties and legal duties, and the latter is what the courts will take into consideration.

¹⁴ Strauss (1964) *South African Law Journal* 183-184 – criminal law, however, focuses more on the interests of the public, and private law on the interests of the individual. Hence the grounds of justification will not necessarily have the same effect in both domains simply because the same standard of reasonableness is used.

¹⁵ Strauss (1964) *South African Law Journal* 183; Carstens & Pearmain 937; *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) at 940J-941A, where a "pre-constitutional test" common law test for wrongfulness is referred to in contrast to a post-constitutional test as developed in terms of S39(2) of the CRSA to accord with the changed *mores* of society as reflected in the values of the CRSA.

¹⁶ Strauss (1964) *South African Law Journal* 183-184; Van der Walt & Midgley 69. Also in general *Van Eeden v Minister of Safety and Security* [2002] 4 All SA 346 (SCA) and the *Carmichele* 2001 cases.

¹⁷ Van der Walt & Midgley 74.

changing needs.¹⁸ Constitutional values and norms should be the “yardstick” against which conduct is evaluated, and should guide to the court as to what South African society’s ideas of reasonableness, fairness and lawfulness are.¹⁹ Because the CRSA is the starting point in making an inquiry into the reasonableness of conduct, it is no longer tenable to view common law principles relating to the *boni mores* in isolation.²⁰ In terms of the CRSA courts and judicial tribunals are obliged to develop the common law – including the common law test for reasonableness – in such a manner that it serves the interests of justice and complies with the objective of promoting the “the spirit, purport and objects of the Bill of Rights”.²¹

Constitutional supremacy does not, however, mean that the CRSA has replaced the common-law concept of the *boni mores*,²² although it goes without saying that in the event of conflicting provisions the CRSA will have precedence over common law.²³

¹⁸ Carstens & Pearmain 937; also S 39(2) of CRSA.

¹⁹ Van der Walt & Midgley 74-75.

²⁰ Van der Walt & Midgley 75.

²¹ Van der Walt & Midgley 74-75; S39(2) and S173 CRSA; *Carmichele* 2001 at 940H-I.

²² Van der Walt & Midgley 5. This misbelief is probably based on an incorrect interpretation of the *Carmichele* case. The *Carmichele* 2001 case. It was held in *Carmichele* 2001 at 940H-I that in terms of S39(2) and 173 of the CRSA, the courts must develop the common law to comply with constitutional values. Nowhere does it state that the common law *boni mores* must be eliminated and replaced entirely by the CRSA – Van der Walt & Midgley 5. The judgement was followed in *Carmichele v Minister of Safety and Security and Another* 2003 (2) SA 656 (C) and in *Minister of Safety and Security and Another v Carmichele* 2004 (3) SA 305 (SCA).

²³ Van der Walt & Midgley 69.

4.4 Specific grounds of justification

4.4.1 Emergencies

The physician may intervene without informed consent in an emergency situation. The right not to be refused emergency medical treatment is contained in section 27(3) of the CRSA, and reiterated in section 5 of the National Health Act.²⁴

The patient should still be informed about their health status, diagnosis, treatment options, benefits, risks, costs, consequences after the emergency treatment has been provided,²⁵ and about their right to refuse further treatment, together with the risks, implications and obligations of this decision.²⁶ Emergency treatment should be kept to the minimum necessary to preserve the patient's life or health.²⁷

Section 9(1)(c) of the MHCA provides specifically for emergency treatment of psychiatric conditions. If treatment has been provided to a user in terms of section 9(1)(c), the Mental Health Review Board for the province must be informed in writing.²⁸

The common law distinguishes two emergency situations that belong under this defence, namely unauthorised administration and necessity. Both could conceivably

²⁴ 61 of 2003.

²⁵ S9 of the National Health Act; par 8.3 of the Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: Seeking patients' informed consent: The ethical considerations* available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf (accessed 2 September 2014) (hereafter the "HPCSA Guidelines on seeking patients' informed consent") (hereafter the "HPCSA Guidelines on seeking patients' informed consent").

²⁶ S8(3) and 6(1)(d) of the National Health Act; McQuoid-Mason D & Dada M (2011) *A – Z of medical law* 94.

²⁷ Par 8.1 of the HPCSA *Guidelines on seeking patients' informed consent*.

²⁸ S9(2) of the MCHA.

be relied upon in both medical- and psychiatric emergencies, provided the relevant validity requirements are met.

Unauthorised administration (*negotiorum gestio*) is traditionally associated with the protection of patrimonial interests of a person in their physical absence.²⁹ But nothing prevents the use of *negotiorum gestio* to justify the protection of the non-patrimonial interests of somebody who is mentally “absent” – a person who is unconscious or mentally impaired is, after all, no more capable of managing their affairs than one who is literally “a thousand miles away”.³⁰

An unauthorised agency may operate as a valid justification provided that:³¹

- an emergency situation exists, meaning that the intervention is immediately necessary, in the face of an immediate threat to the life or health of the *dominus* (the patient);³²
- the patient is unaware or incapable of appreciating the situation;³³
- the intervention has not been expressly forbidden by and is not against the will of the patient;³⁴

²⁹ Strauss & Strydom 238.

³⁰ Strauss SA (1984) *Doctor, patient and the law*, 2nd Ed 72; Strauss & Strydom 238. The effect of the “absence” for purposes of the defence is therefore the same, whether the *dominus* is one’s neighbour who is holidaying at some remote location where they are unreachable, or whether they are a patient who is unconscious as the result of illness or injury.

³¹ See also Nöthling Slabbert, M (2014) ‘South Africa’ in Nys H (ed) (2014) *International Encyclopaedia of Laws: Medical Law 1* at 86-87 for a discussion of unauthorised agency.

³² Strauss (1984) 73; Strauss & Strydom 239; Carstens & Pearmain 907-908. An emergency, in context of medicine, may be described as a situation where the patient may die or suffer irreversible harm to their health if medical assistance is not received timeously – often referred to as “life and death” situations where usual informed consent rules do not apply – McQuoid-Mason & Dada 94; Stoffberg at 150; *Ex parte Dixie* at 751D; *Esterhuizen* at 721C (also *Rompel*, as discussed in *Esterhuizen* at 719D-F); *Burger v Administrateur, Kaap* 1990 (1) SA 483 (C) at 489.

³³ Strauss (1984) 73; Strauss & Strydom 240; Carstens & Pearmain 908. In medicine, the unawareness or absence may be due to unconsciousness, coma, delirium, anaesthetic or another similar factor. Complete unconsciousness is not requisite, however.

- the *gestor* (the physician) must perform the intervention with the intention of acting in the patient's best interests.³⁵ The outcome does not necessarily have to be favourable, as long as the physician acts with the purpose of healing the patient, or protecting his life or health.³⁶

Necessity can also operate as a defence in medical law.³⁷ Like unauthorised agency, the defence also deviates from its traditional pattern in medical law context, in that the prejudiced third party and the person whose rights are being protected, are often one and the same (the patient).³⁸ Necessity is traditionally associated with the prejudice of an innocent third party's rights or interests for the sake of those of another person or of the community.³⁹

In the case of necessity:⁴⁰

- as with unauthorised agency, there should be an emergency situation;⁴¹
- it is irrelevant whether the prejudiced party (the patient) is willing or capable of consenting to the intervention;
- the intervention is performed in the interest of society rather than the patient.

³⁴ Strauss (1984) 74; Strauss & Strydom 241; Carstens & Pearmain 908. This is because unauthorised agency is regarded as a *quasi*-contract on the basis that the *dominus* would have consented to the act, but for their unawareness.

³⁵ Strauss & Strydom 243; Carstens & Pearmain 908.

³⁶ Strauss & Strydom 243; Carstens & Pearmain 908.

³⁷ Nöthling Slabbert 88.

³⁸ Strauss & Strydom 238.

³⁹ Strauss (1984) 71; Strauss & Strydom 237-238; Carstens & Pearmain 909. Necessity could protect the rights of the community, for example through the vaccination of unwilling persons in order to prevent the spread of contagious disease. Where community interests are being protected the defence of necessity will apply even in the face of a mentally competent person's objections.

⁴⁰ See Carstens & Pearmain 909.

⁴¹ There must be an imminent danger, for instance a suicidal person about to jump from a building, and not a longer-term hazard, like a person's habit of taking an excess of sugar in their coffee to the detriment of their health over the long term – Strauss (1984) 71.

4.4.2 Court order

An order of court may serve as a ground of justification, and may be granted against a patient's will.⁴² Section 7(1)(c) of the National Health Act sanctions treatment of users regardless of whether they have consented to it, and whether they have mental capacity to do so, where the treatment itself has been authorised in terms of a law or court order.⁴³ Section 9(1)(b) of the MHCA justifies the provision of mental health treatment authorised by a court order or by a Mental Health Review Board, regardless of whether there is informed consent or not.⁴⁴

4.4.3 Statutory authority

Statutory authority will negate wrongfulness.⁴⁵ The defence may operate in different ways: It could make the patient's consent irrelevant,⁴⁶ as is the case where sections 26, 27, 32, 33 and 40 of the MHCA,⁴⁷ which pertain to the provision of mental health treatment of users who are incapable of making an informed decision about the need for mental health treatment, apply.⁴⁸ In other circumstances,

⁴² Carstens & Pearmain 918. In this regard, see also S7(1)(c) of the National Health Act, S9(1)(b) of the MHCA and par. 11.2 of the HPCSA *Guidelines on seeking patients' informed consent*; Nöthling Slabbert 90.

⁴³ Also McQuoid-Mason D & Dada M (2011) *A – Z of medical law* 97.

⁴⁴ Authorisation by court order also exists as common law justification for the provision of medical- or mental health care services in the absence of the patient's informed consent – see Carstens & Pearmain 918; S7(1)(c) of the NHA.

⁴⁵ Boberg PQR (1984) *The law of delict Volume I, Aquilian liability* 771.

⁴⁶ Carstens & Pearmain 917-918.

⁴⁷ Other examples are S37(2) and 225(2) Criminal Procedure Act 51 of 1977. See also *Minister of Safety and Security and Another v Gaqa* 2002 (1) SACR 654 (C) and *Minister of Safety and Security and Another v Xaba* 2004 (1) SACR 149 (D); S7(1)(d) and 21(2)(k) of the NHA where the failure to provide treatment would pose a threat to public health and immunisation to prevent the spread of communicable disease, respectively. Examples from Carstens & Pearmain 917-918; Nöthling Slabbert 88-89.

⁴⁸ Carstens & Pearmain 918.

statutory authority may overlap with consent,⁴⁹ or it may apply in emergency situations.⁵⁰

4.4.4 Constitutional grounds

The abovementioned grounds do not represent a closed list of justifications.⁵¹ The CRSA allows that conduct may be justifiable based on constitutional grounds.⁵² Conceivably any conduct that infringes on a right in the Bill of Rights but which complies with the standard of reasonableness as it resonates in section 36 of the CRSA, may be justifiable – as such the CRSA can be employed successfully to deflect civil claims and avoid criminal liability.

4.4.5 A “professional right to cure”?

The professional right or vocational right to cure has been advanced as justification or basis for medical interventions in the absence of informed consent.⁵³ The acknowledgement of a right or duty to cure would fly in the face of values of individualism, autonomy and self-determination.⁵⁴ There can be no room for such a right in South African medical law.⁵⁵

⁴⁹ For instance in the case of abortion, sterilisation and organ- or tissue transplant - Carstens & Pearmain 918; Nöthling Slabbert 89-90.

⁵⁰ Carstens & Pearmain 918; Nöthling Slabbert 90.

⁵¹ Van der Walt JC & Midgley JR (2005) *Principles of delict 3rd Ed* 126; *Clarke v Hurst* 1992 4 SA 630 (D) 650H-I; Carstens & Pearmain 937. Two other examples of grounds of justification are therapeutic privilege and relative impossibility – Carstens & Pearmain 873.

⁵² Carstens & Pearmain 873.

⁵³ Strauss & Strydom 178; Strauss (1984) 3.

⁵⁴ Van Oosten FFW ‘Castell v de Greef and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy’ (1995) 28 *De Jure* 164 at 167. *Stoffberg* at 149-150; *Ex parte Dixie* at 751C-D.

⁵⁵ Strauss & Strydom 178; Claassen & Verschoor 58.

4.5 Liability issues

4.5.1 Grounds of liability

As a rule, the provision of medical treatment in the absence of informed consent or another extenuating circumstance is wrongful, and could see the clinician incurring liability for his or her efforts.⁵⁶

Depending on the particular conduct, the ramifications of failure to obtain consent can include liability based on breach of contract,⁵⁷ delict,⁵⁸ crime,⁵⁹ negligence,⁶⁰ professional censure or a combination of the aforementioned.⁶¹ Further in consequence of the failure to obtain consent, the doctor or hospital could forfeit their professional fee,⁶² or face disciplinary action in terms of the Health Professions Act.⁶³

The doctor's motives or intentions make no difference to the aspect of liability,⁶⁴ nor does the degree of care and skill with which the procedure is executed, or whether

⁵⁶ Strauss & Strydom 179; Strauss (1984) 3; Van Oosten (1995) *De Jure* 166; Giesen 252; *Zurnamer v Thielke* 1914 CPD 176 at 176; *Palmer v Palmer* 1955 (3) SA 56(O) at 59E-F; *Castell* 1994 at 420H-I.

⁵⁷ Van Oosten (2000) *THRHR* 12; *Castell* 1994 at 425D-E; Nöthling Slabbert 70.

⁵⁸ This would be on the basis of civil assault, constituting a violation of the patient's physical integrity – Van Oosten (1995) *De Jure* 166-167; *Stoffberg* at 148; *Esterhuizen* at 718A; *Richter* at 232F-G; *Broude v McIntosh and Others* 1998 3 SA 60 (SCA) at 60G-H; alternatively civil *iniuria*, as violation of the patient's dignity and/or privacy – Van Oosten (1995) *De Jure* 166-167; *Stoffberg* at 152; *Seetal v Pravitha and Another NO* 1983 3 SA 827 (D); *C v Minister of Correctional Services* at 300H-J and 306B-E. See also Carstens & Pearmain 871; Nöthling Slabbert 70-71.

⁵⁹ Criminal *iniuria* or criminal assault – *S v Sikunyana and Others* 1961 (3) SA 549 (E) at 551A; Van Oosten (2000) *THRHR* 12; Nöthling Slabbert 70-71.

⁶⁰ *Lymbery* at 236 (see also the acts of negligence as pleaded by the appellant (plaintiff) at 239); *Richter*, *Castell* 1993 517G-I; *Prowse v Kaplan* 1933 EDL 257 at 257; *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W) at 269C-270A (dealing with the failure to warn and instruct the patient about the prevention of Volkmann's contracture); Van Oosten (2000) *THRHR* 12; Nöthling Slabbert 71.

⁶¹ Carstens & Pearmain 872; *Stoffberg* at 149-150.

⁶² *McCallum v Hallen* 1916 EDL 74; *Recsei's Estate v Meine* 1943 EDL 277 at 290 Nöthling Slabbert 71.

⁶³ 56 of 1974. See McQuoid-Mason & Dada 93-94.

⁶⁴ Giesen 261; *Esterhuizen* at 710G.

the eventual outcome was to the patient's benefit.⁶⁵ This is because an intervention performed without informed consent is considered to be an act in violation of the patient's physical integrity, *dignitas* or privacy, and not an act against his health.⁶⁶

4.5.2 Failure to inform: assault or medical negligence?

The question of whether the failure to obtain informed consent prior to a medical procedure constitutes assault or medical negligence has been the subject of some debate.⁶⁷ Precedent exists to support both possibilities.⁶⁸

In the matter of *Lymbery v Jeffries*,⁶⁹ the failure on the part of the respondent (defendant) to inform the appellant (plaintiff) of risks inherent in treatment was dealt with on the basis of medical negligence, as pleaded by the plaintiff.⁷⁰ The court did not find the defendant liable for his failure to warn the plaintiff,⁷¹ but did not give any clear indication either, as to whether the defendant's omission would have amounted to negligence if he had been found liable.⁷²

A claim based on medical negligence in the absence of informed consent (the failure to inform) was also entertained in the *Richter* case.⁷³ The defendant was not found liable on the facts. Had the matter been decided otherwise, the judgement would

⁶⁵ This makes consent a "justification in the technical sense of [the] word." – Strauss (1964) *South African Law Journal* 187; Claassen & Verschoor 58; Van Oosten (1995) *De Jure* 167.

⁶⁶ Van Oosten (1995) *De Jure* 167.

⁶⁷ Claassen & Verschoor 71; Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (unpublished LLD thesis) University of Pretoria (1996) 173.

⁶⁸ Carstens (1996) LLD thesis 173.

⁶⁹ 1925 AD 236 at 240.

⁷⁰ *Lymbery* at 240, 239. The court states at 238 that "[t]his absence of warning is negligence and possibly assault, because of the absence of consent."

⁷¹ It was not disputed that the respondent (defendant) had told Mrs Lymbery prior to the treatment that she "would not see her menstrual periods again" (*Lymbery* at 240). The court held that it should have been apparent to her that she would not be able to have any more children after the treatment.

⁷² See also Strauss (1984) 325; Claassen & Verschoor 72.

⁷³ At 226 & 232F. See also discussion in Strauss (1984) 323-324.

have seen certain established principles of common law completely re-written.⁷⁴ The test for negligence in Roman-Dutch law traditionally has to do with the foreseeability and preventability of harm, and in medical malpractice cases, relates to incompetent or unskilful treatment.⁷⁵ This test is distinct from that for common law assault.⁷⁶ To have confounded the issue in a reported judgement would have no doubt led to widespread confusion.

The matter of *Broude* is again decided on medical negligence, and Marais JA goes so far as to label the categorisation of absence of informed consent as assault as “bizarre” and “unsound”.⁷⁷ It is respectfully submitted that this view fails to fully take into account the technical definition of assault as described in the paragraphs which follow. As should become apparent, there is nothing to suggest that assault in the technical sense is essentially an issue of subjective ill-intent or malice on the part of the doer.

The majority of authors and reported judgements are *ad idem* that to regard assault as the ground of liability for failure to inform (and hence failure to obtain informed consent), is the correct and proper view.⁷⁸ The technical, common law definition of assault involves “...an intentional application of force or violence... to the person of another...”⁷⁹ In the technical sense the act of administering medical treatment, even a perfectly successful therapeutic procedure, is nothing other than an act of violence or physical force on the patient’s person, and as such should constitute an assault

⁷⁴ Claassen & Verschoor 72.

⁷⁵ *Lymbery* at 239; Claassen & Verschoor 72; Nöthling Slabbert, M (2014) ‘South Africa’ in Nys H (ed) (2014) *International Encyclopaedia of Laws: Medical Law* 1 at 95.

⁷⁶ As defined below.

⁷⁷ *Broude* at 68A-F. The correctness of the decision in *Castell* 1994 is not challenged, however.

⁷⁸ Claassen & Verschoor 72; Carstens & Pearmain 497-500. Also, with reference to the defence of consent in the context of medical law, reference was once made to the so-called “permission to assault” cases – Boberg 724; *Stoffberg* at 148; *Esterhuizen* in general and *Lampert* at 508F.

⁷⁹ *R v Jolly and Others* 1923 AD 176 at 184. Also of interest in the context of medicine, and pharmacology, is the judgement in *S v Marx* 1962 (1) SA 848 (N), where the court confirms that the administration of a noxious substance to an unwitting victim, amounts to assault (in this case the substance was alcohol, which is “not a poison in the ordinary sense of the term... [but can] ...cause considerable bodily harm in certain circumstances”) - at 854B.

unless it can be justified on legally accepted grounds.⁸⁰ The question should, of course, also be viewed in the context of an infringement of the constitutional right to bodily- and psychological integrity and the right to freedom from violence in terms of section 12(2)(b) read with section 12(1)(c) of the CRSA.⁸¹

The *Stoffberg*-case is generally regarded as the “...*locus classicus* on the right to administer medical or surgical treatment (which is an assault unless it is legally justified...)”.⁸² In the words of Watermeyer J in his instruction to the jury:

Any bodily interference with or restraint of a man’s person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.⁸³

The plaintiff in the matter of *Esterhuizen v Administrator, Transvaal* was a young girl of fourteen who suffered from Kaposi’s haemangiosarcoma.⁸⁴ The plaintiff initially underwent superficial X-ray treatment, and later deep X-ray treatment. The deep therapy X-ray treatment resulted in severe disfigurement of the plaintiff, including the loss of both her legs and her right hand. The plaintiff instituted a claim on the basis of assault, and negligence in the alternative, and succeeded based on the basis of assault in the absence of informed consent.⁸⁵

⁸⁰ The medical intervention in itself is an act of force or violence in the sense that it constitutes a bodily interference or “*Körperverletzung*” – Strauss (1964) *South African Law Journal* 187; Strauss & Strydom 180-181.

⁸¹ Claassen & Verschoor 72; Carstens & Pearmain 497-500; Currie & de Waal 281, 287. See also discussion of S12 of the CRSA in chapter 2 hereof.

⁸² *Stoffberg* at 148-150; Boberg 746.

⁸³ *Stoffberg* at 148.

⁸⁴ Kaposi’s haemangiosarcoma is a type of malignant neoplasm associated with the recurrent appearance of varicelliform eruptions or tumour-like nodules, especially on the skin of the extremities – see Stedman, TL *Stedman’s medical dictionary 28th Ed* (2006) 1020 & 1720; Dorland *Dorland’s Illustrated Medical Dictionary 32nd Ed* (2012) Philadelphia: Elsevier, Saunders 1657.

⁸⁵ *Esterhuizen* at 710G-H; Strauss (1984) 325.

The case serves to confirm that, in the light of the patient's right to self-determination and physical integrity, unless another justification such as an emergency situation exists, informed consent to medical treatment is requisite and in its absence the treating physician – no matter how laudable his or her motives – should be held liable based on assault.⁸⁶

The matter of *Castell*,⁸⁷ serves to confirm that the issue of failure to inform does not surround medical negligence but is rather about consent to injury or assumption of risk of harm.

Based on the common law definition of assault, and the legally unsound consequences if the absence of informed consent as medical negligence were to be entertained, it is submitted that medical treatment in the absence of informed consent can be correctly construed as amounting to assault.⁸⁸

4.5.3 Proof of medical negligence prerequisite to a claim based on the absence of consent: *Sibisi NO v Maitin*

In the recent judgement of *Sibisi NO v Maitin*,⁸⁹ the issues of medical negligence and the absence of informed consent were again considered by the Supreme Court of Appeal. The court in *Sibisi* ruled, unanimously, that once the plaintiff has failed to establish medical negligence, the question of informed consent and of wrongfulness automatically becomes irrelevant.⁹⁰

⁸⁶ *Esterhuizen* at 721B-D.

⁸⁷ 1994 at 425E-F & 420H-I.

⁸⁸ Besides assault it could possibly also be construed as *crimen iniuria* – Strauss (1984) 3. See also *Burger v Administrateur, Kaap* 1990 (1) SA 483 (C) at 489A-B; Carstens & Pearmain 687.

⁸⁹ (311/13) [2014] ZASCA 156 1 October 2014.

⁹⁰ *Sibisi* at 15, par [50].

This approach seemingly fails to take cognisance of the fact that wrongfulness is evaluated separately from fault, and that the form of fault in absence of informed consent (which amounts to common law assault) is that of *dolus* rather than *culpa*, as is the case in medical negligence.

It has in the past not been required, in order for the patient to successfully institute a claim for delictual damages on account of an absence of informed consent, to prove negligence on the part of the attending physician.⁹¹ The fact that the patient's physical integrity had been invaded without his or her consent has traditionally been regarded as sufficient cause for liability, as the question of assault in the form of absence of informed consent is evaluated separately from that of medical negligence.⁹²

The judgement in *Sibisi* is similar to that in *Richter, supra*, in that the issues of and tests for medical negligence and assault (the absence of informed consent) seem to have been confused. Medical negligence and the absence of informed consent should exist as two separate, independent alternative claims. It is respectfully submitted that applying the *Sibisi* judgement in future would most likely lead to legally unsound consequences.

4.6 Conclusion

This chapter has sought to explain the possible justifications for the provision of medical- or psychiatric treatment in situations where the patient's informed consent cannot be obtained.

⁹¹ Strauss & Strydom 180.

⁹² Strauss & Strydom 180. From the facts it appears as if the plaintiff in *Sibisi* would not have succeeded on the basis of either ground, in any event, so that the practical outcome would have remained the same.

A short exposition was given of the grounds of justification in terms of, firstly, their place among the multiple defences available to the defendant-physician, and secondly of their operation as defences which nullify the wrongfulness of an act. Specific grounds of justification which could be relied upon as alternatives to the defence of *volenti non fit iniuria* were discussed, with reference to the common law, CRSA and relevant legislative provisions.

Liability in the absence of informed consent was discussed. It was found that the correct ground of liability for the failure to obtain prior consent to a medical procedure, should be assault rather than medical negligence. Reference was then made to relevant case law which made the proof of medical negligence necessary in order to prove a claim based on the absence of consent. It was submitted that such an approach was not feasible.

Chapter 5

Informed consent and mental capacity in the context of the Mental Health Care Act 17 of 2002

5.1 Introduction

The promulgation of the Mental Health Care Act (the “MHCA”)¹ has gone a long way towards improving upon the unconstitutionality of its predecessor.² The MHCA echoes international attitudes toward mental health in acknowledging that health must include mental health.³ The MHCA provides for treatment under different categories, depending on the user’s mental health status and circumstances. New procedures are established for treatment under each of these categories. The MHCA gives rise to many technical uncertainties, however. A number of its provisions are vague or insufficient, particularly those pertaining to informed consent and mental capacity of mental health care users (“users”).

This chapter will seek to render an analysis of the impact of the MHCA on the mental health system in South Africa, with specific focus on the aspect of informed consent

¹ 17 of 2002, as amended (the “MHCA”).

² Being the Mental Health Act 18 of 1973, which has been repealed in part by the MHCA, and later in its entirety by the Mental Health Care Amendment Act 12 of 2014. See Zabow T ‘The Mental Health Care Act (Act 17 of 2002)’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 58 at 58.

³ Preamble to the MHCA. The World Health Organization (hereafter the “WHO”) is one international entity which follows a holistic approach to mental health care, which is evident from their proposed definition of mental health as ... “[a] state of complete physical, mental and social well-being, and not merely the absence of disease”. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders – World Health Organization (2014) *Mental Health* available at http://www.who.int/topics/mental_health/en/ (accessed 12 September 2014).

and mentally ill persons' capacity to consent to mental health care, treatment and rehabilitation ("mental health treatment"). The focus will be shifted to the right to consent to mental health treatment in terms of the MHCA, and the infringements upon this right permitted by the MHCA.

It will begin with a short exposition of the right to informed consent as found in section 9 of the MHCA, which includes the general rule that a mental health care user ("user") may make his own decisions about mental health care, the exception that mental health care may be provided with authorisation by a court or Mental Health Review Board, and in the event of a psychiatric emergency as meant in section 9(1)(c).

The categories of voluntary- assisted- and involuntary users will each be discussed in turn, with reference to the definitions and admission procedures of each category. Discussions will follow of the initial review and periodical reports as well as appeal procedures, which are applicable to assisted- and involuntary users, and to the possibility of regaining mental capacity, refusal of further treatment and subsequent relapse. Reference will be made to certain provisions of the National Health Act 61 of 2003 which may apply to the psychiatric context, concurrently with the MHCA.

5.2 The right to consent to mental health treatment

5.2.1 Prohibition on mental health treatment-provision without prior consent

In terms of section 9(1) of the MHCA, the user's right not to be subjected to mental health treatment except in very specific circumstances is reiterated. As a general rule, the user has the right to decide for himself about whether or not to undergo

any form of mental health treatment.⁴ Section 9(1)(a) provides for treatment-provision to a user who has consented to it, and section 9(1)(b) allows the provision of mental health treatment if authorised by a court or Mental Health Review Board.

5.2.2 Psychiatric emergencies

Except for the two situations provided for in terms of sections 9(1)(a) and (b) of the MHCA, mental health treatment may be provided to a user without their informed consent in the event of a psychiatric emergency in terms of section 9(1)(c) of the MHCA. Emergency treatment in terms of section 9(1)(c) may be provided if the user is suffering from mental illness and a delay in treatment may result in:

- the death of or irreversible harm to the health of the user;
- the user inflicting serious harm to themselves or others; or
- the user seriously damaging or destroying their own or others' property.⁵

Emergency treatment in accordance with section 9(1)(c) may not be provided for longer than twenty-four hours. If further treatment is necessary, an application must be made in terms of chapter V of the MHCA before the twenty-four hour time period lapses.⁶

⁴ Also Landman & Landman 31.

⁵ S9(1)(c) of the MHCA read with Reg 8 contained in the General Regulations to the MHCA, published under GN R1467 in GG 27117 of 15 December 2004 as corrected by GN R98 in GG 27236 of 11 February 2005. The application for emergency psychiatric treatment is done on form MHCA 01, which, like form MHCA 15 (which deals with appeals), is regarded as an "emergency form" by the Mental Health Review Board and Secretariat, and are dealt with as a matter of priority – E Mathoda, personal communication, 21 January 2015.

⁶ S9(2)(b) of the MHCA. In addition, common law determines that any mental health treatment rendered during a psychiatric emergency should be kept to the minimum necessary to stabilise the situation – Dada MA & McQuoid-Mason DJ (eds) (2001) *Introduction to medico-legal practice* 111.

5.3 Voluntary mental health care users

5.3.1 Definition, requirements and procedure for voluntary mental health treatment

Section 9 of the Mental Health Care Act bears the first explicit mention of consent to mental health treatment.⁷ The provision forms part of patient chapter III of the Act, which deals with patient rights and duties. Section 9(1)(a) provides that mental health treatment may be provided to a user who has consented thereto. This relates to voluntary mental health treatment, which is defined, again, as the provision of health interventions to a person who has given consent thereto.⁸

Section 1(xi) of the MHCA defines “voluntary care, treatment and rehabilitation” as:

...the provision of health interventions to a person who gives consent to such interventions.

The voluntary user is a mentally ill, but competent person, willing to undergo psychiatric treatment and who submits voluntarily at an establishment for this purpose. Upon voluntary submission at an establishment the user will be entitled to appropriate care or referral.⁹ The MHCA does not regulate the admission procedure of voluntary users, and the procedure depends on the particular establishment’s policies and procedures.¹⁰ The same applies to discharge procedures for voluntary users.¹¹ A voluntary user who no longer wishes to receive mental health treatment

⁷ It would be untenable to interpret “consent” in context of the MHCA as anything other than informed consent – Van Oosten 1989 LLD thesis 20-24. See discussion of common law informed consent in chapter 3 of this dissertation.

⁸ S1(xi) of the MHCA.

⁹ S9(1)(a) & S25 read with S6(1)(a)-(b) of the MHCA.

¹⁰ Landman & Landman 89.

¹¹ Landman & Landman 89.

may ask for discharge or cessation of mental health treatment at any time that they wish to do so.¹²

The Act places voluntary users in very much the same position as any other type of patient who seeks treatment for any other kind of ailment.¹³ Owing to considerations of trust, respect for autonomy and improved treatment outcomes and compliance, voluntary mental health treatment is generally considered the preferable mode of treatment.¹⁴

5.3.2 Reclassification of voluntary users

The voluntary user's status may be changed to that of an assisted user if their condition deteriorates, which inevitably places limitations on their personal choices and freedoms.¹⁵

5.4 Assisted mental health care users

5.4.1 Definition and prerequisites of assisted mental health treatment

Section 1(ii) of the MHCA defines "assisted care, treatment and rehabilitation" as:

...the provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions.

¹² D Meeko, personal communication, 21 January 2015.

¹³ Moosa & Jeenah (2008) *African Journal of Psychiatry* 109.

¹⁴ Dada & McQuoid-Mason 103; Moosa & Jeenah (2008) *African Journal of Psychiatry* 109.

¹⁵ D Meeko, personal communication, 21 January 2015.

An assisted user is a person receiving assisted care.¹⁶ They have also been referred to as “reluctant or unresponsive users”.¹⁷ As soon as a user expresses or displays a refusal of consent to mental health treatment, they can no longer be treated as an assisted user.¹⁸ Mental health care may be provided to a user on an assisted basis if a written application has been approved by the head of establishment. At the time of the application:

- there must be a reasonable belief that the user is suffering from either a mental illness or a “severe or profound mental disability”;¹⁹ and
- that they require care for the sake of their own health or safety, or that of others; and
- the user must be “incapable of making an informed decision” regarding the need for mental health care.

5.4.2 Procedural aspects regarding assisted mental health treatment

An applicant who wishes to apply for a user’s assisted mental health treatment can do so by completing MHCA 04 of the Annexure to the Act’s regulations and

¹⁶ S1(iii) of the MHCA.

¹⁷ Landman & Landman 91.

¹⁸ Landman & Landman 91.

¹⁹ Defined in terms of the MHCA as “a range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self-care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care”. Mental disability is distinct from mental illness.

submitting the form, which must be certified by a Commissioner of Oaths, to the head of the health establishment.²⁰

The head of establishment will then arrange for the user to be examined by two independent mental health care practitioners, at least one of whom must be qualified to conduct physical examinations.²¹ After the examination each practitioner submits his findings to the head of establishment on form MHCA 05.²² The practitioners must report on whether the circumstances necessary for assisted treatment are present, and on whether inpatient or outpatient treatment would be more appropriate for the user.²³ In practice, form MHCA 05 is usually completed by a psychiatric professional nurse (not any nurse)²⁴ and a doctor, alternatively by two doctors.²⁵

If the practitioners concur that the criteria mentioned in section 26 are present,²⁶ and also depending on whether if the head of establishment is satisfied that the infringement on the user's freedom of movement, privacy and dignity are proportionate to the treatment, he may either approve or decline the application for

²⁰ S27(1) of the MHCA read with Reg 9(1) & Reg 9(4); M Swanepoel, personal communication, 8 April 2014; Landman & Landman 93. The applicant is usually a family member of the user or an "associate, defined in terms of S1(iv) of the MHCA as someone who has a "substantial or material interest" in the user's well-being and who has substantial contact with the user.

²¹ S27(4) of the MHCA.

²² S27(4) of the MHCA read with Reg 9(3).

²³ S27(5) of the MHCA.

²⁴ The psychiatric professional nurse is a nurse who has completed a standard nursing qualification, which usually involves a diploma from a nursing college after 3-4 years' training, and includes training at various teaching hospitals. The psychiatric professional nurse would then have specialised by completing an additional 6-12 month diploma in psychiatric nursing. See Kaliski S 'Appendix: Mental health practitioners: the psychiatric professional nurse' in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 382 at 382.

²⁵ E Mathoda, personal communication, 21 January 2014.

²⁶ In the event that the practitioners disagree, S6(a) provides that the head of establishment may appoint a third practitioner whose opinion will be decisive.

assisted care. The head of establishment gives notice of their decision to the applicant by completing form MHCA 07.²⁷

If the decision is to approve the application for assisted care on an inpatient basis, the head of establishment must cause the user to be admitted within five days.²⁸ From admission onwards, the procedures for initial review, periodical reports and appeals as explained below, will apply.

5.5 Involuntary mental health care users

5.5.1 Definition and prerequisites of involuntary mental health treatment

Section 1(xiii) of the Act defines involuntary care, treatment and rehabilitation as:

...the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others...

An involuntary mental health care user, according to section 1(xiv) is someone receiving involuntary mental health care. Section 32 of the MHCA provides that mental health care “must”²⁹ be provided to a user without their consent if a written application is made and granted, and at the time of the application there is a reasonable belief that:

²⁷ S27(9) of the MHCA read with Reg 9(7).

²⁸ S27(10) of the MHCA. S40 of the MHCA allows the head of establishment to request assistance from the South African Police Service (SAPS) to have the user brought to the establishment or transferred to another suitable establishment, if necessary. Landman & Landman 98.

²⁹ As opposed to “may” (“may not, unless”) as used in S26.

- the user is suffering from a mental illness; and
- the mental illness is such that it is likely to result in the user inflicting serious harm upon themselves or others, or is such that mental health care is necessary in order to protect the user's financial interests or reputation; and
- the user is "incapable" of making an informed decision on the need for mental - health care; and
- the user is and must be unwilling to receive the necessary care.

Within the Gauteng province, common diagnoses within the involuntary category of user include schizophrenia; substance-induced psychosis (heroin and cocaine among affluent communities, and dagga, *nyaope*,³⁰ alcohol and mandrax common among users from townships); bipolar mood disorder and depressive disorders; post-partum psychosis and suicide.³¹

5.5.2 Procedural aspects regarding involuntary mental health treatment

The procedure for involuntary treatment, up to the completion of form MHCA 07 by the head of the health establishment, is basically the same as that of an application for assisted treatment. The applicant will submit a completed and certified form MHCA 04 to the head of establishment for consideration,³² following which the user will be examined by two practitioners, each of whom submits a completed report on

³⁰ *Nyaope* is a relatively new, inexpensive combination of drugs typically consisting of a mixture of dagga, heroin with various "cutting agents" (rumoured to include anything from crushed antiretroviral medication, detergent, milk powder and rat poison). See Moodley SV, Matjila MJ & Moosa MYH 'Epidemiology of substance use among secondary school learners in Atteridgeville, Gauteng' (2012) 18 *South African Journal of Psychiatry* 2 at 4.

³¹ D Meeko, personal communication, 21 January 2015. It is not altogether uncommon for teens as young as 10-12 years of age to present with suicidal ideation or to attempt suicide.

³² S33(1) of the MHCA read with Reg 10(1).

form MHCA 05.³³ Based on the two reports, the head of establishment then makes a decision on further treatment and gives notice thereof to the applicant on form MHCA 07.³⁴

If the decision was to approve inpatient involuntary treatment, the user must be admitted for the 72-hour observation period within forty-eight hours.³⁵

5.5.3 72-hour assessment of involuntary users

Unlike an assisted user, an involuntary user is subjected to a 72-hour assessment in terms of section 34 of the MHCA, before any subsequent provision of mental health treatment. The assessing practitioners must make a provisional diagnosis of mental illness at the initiation of the assessment and must commence treatment according to standard protocols and guidelines as soon as possible.³⁶

The 72-hour assessment is done by a medical practitioner and another mental health care practitioner, and may take place at a general hospital.³⁷ The assessment is meant to be an assessment of the user's physical- and mental health status, including a multidisciplinary evaluation of his medical-, psychological-, educational-, social-, financial- and legal situations.³⁸ After the assessment, each practitioner submits a written report about his findings on form MHCA 06.³⁹

³³ S33(4) of the MHCA read with Reg 10(3) and Reg 10(5).

³⁴ S33(8) read with Reg 10(7) of the MHCA.

³⁵ S33(9) of the MHCA.

³⁶ Regulation 11(4) of the MHCA; Landman & Landman 116.

³⁷ This allows for an assessment of the user during the acute phase of illness, in a place that needn't be too far away from home – Freeman M 'New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health' (2002) *South African Psychiatry Review* 4 at 7.

³⁸ Moosa & Jeenah (2008) *African Journal of Psychiatry* 110.

³⁹ S34(1) read with Reg 11(1) & Reg 11(6) of the MHCA. Form MHCA 06 makes provision for assessment of whether the user is suicidal, homicidal, or dangerous.

The practitioners must determine whether continued involuntary care is appropriate, and whether such care should be on inpatient- or outpatient basis. The user's physical state might stabilise during the 72 hours and his mental state may improve enough so that involuntary inpatient treatment becomes inappropriate.⁴⁰ A less restrictive option, and one which involves lesser stigma and a lesser loss of dignity and freedom, such as involuntary outpatient treatment or voluntary treatment, could become a possibility for the user.⁴¹

The head of establishment must make a finding and give notice of the decision to the applicant on form MHCA 08.⁴² Depending on what the decision was, the user would then be discharged completely, discharged to continue outpatient treatment, kept at the assessing hospital or transferred to an appropriate psychiatric institution for involuntary treatment.

5.5.4 Involuntary users referred by a criminal court

Aside from the procedure provided for in terms of chapter V of the MHCA (the "civil route"),⁴³ a second type of involuntary user exists who has been referred to an establishment in terms of the criminal justice system.⁴⁴

A user may be referred from the criminal justice system to be treated as an involuntary user in two circumstances. Firstly, a presiding officer may suspect that an accused who has committed an offence (except murder, culpable homicide, rape or compelled rape in terms of section 3 or section 4 of the Criminal Law (Sexual

⁴⁰ Freeman (2002) *African Journal of Psychiatry* 7. If sufficiently improved, the user might be eligible for continued voluntary treatment at this point in accordance with Reg 11(7) of the MCHA.

⁴¹ Freeman (2002) *African Journal of Psychiatry* 7. If a user fails to comply with involuntary outpatient treatment, however, the head of establishment may have him return to the institution for involuntary inpatient treatment – S34(6) of the MHCA; Landman & Landman 120.

⁴² Either on form MHCA 08 or MHCA 09.

⁴³ Landman & Landman 109.

⁴⁴ Landman & Landman 109; E Mathoda, personal communication, 21 January 2015.

Offences and Related Matters) Amendment Act 32 of 2007, or an offence involving serious violence)⁴⁵ is incapable due to mental illness of understanding the criminal proceedings and may refer him for 30 days' observation at an establishment in terms of section 77 of the Criminal Procedure Act 51 of 1977. If after observation, the accused is found incapable of understanding the proceedings and making a proper defence, the court may have him admitted to a mental health establishment as if he were an involuntary user as meant in section 37 of the MHCA.⁴⁶

Secondly, if an accused who has committed any kind of criminal offence is found to have lacked criminal capacity in terms of section 78 of the Criminal Procedure Act, the court may have him admitted to an establishment for treatment as if he were an involuntary user as meant in section 37 of the MHCA.⁴⁷

In neither instance does the usual "civil" procedure of chapter V of the MHCA apply, and what remains for the involuntary user referred by a criminal court is the periodic review at six months following admission and every 12 months thereafter.⁴⁸ This procedure allows that the mentally ill offender may be granted leaves of absence from the institution. Furthermore, there is the risk that such a user might simply be discharged from the institution without authorisation from court, and so effectively "drop out" of the criminal justice system.⁴⁹

5.6 Initial review and periodical reports

The MHCA accords with international recommendations relating to automatic periodical review mechanisms where long-term mental health treatment is involved, on account of the long-standing infringement on integrity and/or personal liberty of

⁴⁵ Landman & Landman 109.

⁴⁶ Landman & Landman 109-110.

⁴⁷ Landman & Landman 110.

⁴⁸ Landman & Landman 110.

⁴⁹ M Swanepoel, personal communication, 21 January 2015.

the user.⁵⁰ Changes to the MHCA include more frequent review for involuntary- and assisted users, State patients and mentally ill prisoners.⁵¹ The initial report in respect of assisted- and involuntary users must be done within thirty (30) days of receipt by the Mental Health Care Board of the head of establishment's decision about assisted- or involuntary treatment.

Following the initial report, a periodic review in respect of the user must be conducted after the first six months, and every twelve months thereafter. The periodical reports are meant to determine whether the user is still suffering from mental disorder; is still mentally incapacitated, and whether alternative less restrictive treatments may be more suitable for him.⁵² It provides the opportunity for recommendations to be made about further treatment.⁵³ Within 30 days of receiving the periodical report, the Board must decide on a course of action (whether to discharge, or recommend other treatment).

The initial report at six months is recorded on form MHCA 14, and the periodical reports every twelve months thereafter, on form MHCA 13A.⁵⁴ The first periodical report (the initial report) must be done by a medical practitioner, as must every other periodical report thereafter, and the remainder of the periodical reports may be done by any mental health care practitioner.⁵⁵

⁵⁰ See UN Principle 17(3) and WHO Principle 8.

⁵¹ S28, 30 & 37 of the MHCA; Zabow 60.

⁵² S30 in respect of assisted users, and S37 for involuntary users.

⁵³ Landman & Landman 103.

⁵⁴ E Mathoda, personal communication, 21 January 2015.

⁵⁵ Reg 21(1)(b)-(c).

5.7 Appeal procedures

In accordance with international guidelines,⁵⁶ the MHCA affords a user the right to lodge an appeal against the head of establishment's decision about assisted treatment.⁵⁷ A user,⁵⁸ spouse, family member, partner, associate, parent or guardian ("the appellant") must within 30 days of receiving the notice from the head of establishment on form MHCA 07, make appeal by completing form MHCA 15, which must be submitted either to the head of establishment or directly to the Mental Health Review Board.⁵⁹

The Mental Health Review Board must, within thirty days of receipt of form MHCA 15, obtain the necessary documentation, provide relevant parties with the opportunity to make representations on the merits of the matter, consider the appeal and provide a written report of their decision together with reasons.⁶⁰

When considering an appeal, the Review Board should take into account the principle of least infringement, or least restrictive treatment – appeals have been granted by the Board (depending on circumstances such as social support), where an involuntary patient asked to be changed from involuntary inpatient- to outpatient status, offering as alternative private mental health care practitioners which she would consult with.⁶¹ Applications of this kind have been granted, as one cannot

⁵⁶ UN Principle 17 and WHO Principle 7.

⁵⁷ S29 read with Reg 13 & S35 read with Reg 14 of the MHCA for assisted- and involuntary users, respectively.

⁵⁸ Where the user is also the mentally ill person, appeal proceedings may be problematic in the sense that, while one cannot constitutionally justify denying the user the right to an appeal, he may be unable, owing to his mental illness, to understand the appeal proceedings – M Swanepoel, personal communication, 8 April 2014.

⁵⁹ Landman & Landman 99-100.

⁶⁰ Because users' rights are at stake, care is taken to handle appeals in a timeous and efficient manner, and as such form MHCA 15 is considered an "emergency form" by the Secretariat and Mental Health Review Board. A separate register is kept by the Secretariat in which all appeals are recorded – E Mathoda, personal communication, 21 January 2015.

⁶¹ One such instance is that of a user suffering from anorexia nervosa, who recently applied to be discharged from a state mental health facility and to continue involuntary treatment on an outpatient basis under the care of private sector mental health care practitioners. The user's appeal was

justifiably deprive the user of the right to choose service providers, if circumstances are such that outpatient treatment is viable.⁶²

Should a mental health care user be dissatisfied with a decision by the Mental Health Review Board, it is submitted that, aside from the procedures provided for in terms of the MHCA itself, he could still find recourse in section 33 of the CRSA read with the Promotion of Administrative Justice Act.⁶³

5.8 Regaining mental capacity: the “revolving door syndrome”

The MHCA forbids the continued assisted- or involuntary treatment of a user who has regained their decision-making capacity.⁶⁴ Ironically the psychiatric treatment rendered on an assisted- or involuntary basis is often precisely what leads to the recovery of mental capacity. Users who lacked insight into their condition to begin with tend to refuse further treatment once their symptoms improve,⁶⁵ which predictably leads to relapse and readmission. The cycle is known as the “revolving door syndrome”.⁶⁶

granted – M Swanepoel, personal communication, 21 January 2015. It should be mentioned that this particular user was permanently employed and had a good social support system. Had this not been the case, the Board would probably not have been in a position to grant the appeal.

⁶² M Swanepoel, personal communication, 21 January 2015.

⁶³ 3 of 2000. This should hold true by virtue of review boards being administrative- or *quasi-judicial* rather than judicial bodies.

⁶⁴ As provided for in S31 and S38 of the Act, respectively. The user may, of course, consent to continued treatment on a voluntary basis in terms of S25 of the MHCA.

⁶⁵ Swanepoel M *Law, psychiatry and psychology: a selection of constitutional, medico-legal and liability issues* (unpublished LLD dissertation) UNISA (2009) 127.

⁶⁶ Behr GM, Christie C, Soderlund N & Lee T ‘Patterns and determinants of acute psychiatric readmissions’ (2002) 8 *South African Journal of Psychiatry* 71 at 72. This situation has implications on an ethical- as well as constitutional level. One is no doubt infringing upon the user’s fundamental rights in providing mental health care without informed consent. The justifiability of the infringement, in the light of the possibility that it might only lead the user down the path of repeated re-admissions, can be called into question. It becomes even more problematic in the light of the fact that the “balancing” exercise of individual and collective rights in terms of the constitution is perhaps difficult to

The cycle of relapse and readmission is more commonly associated with diagnoses such as schizophrenia, bipolar disorder and comorbid substance-related disorders, particularly if the illness is severe, of long duration, and if there have been many previous psychiatric admissions.⁶⁷ Other more chronic conditions such as personality disorders, brain damage and severe mood disorders are also associated with the phenomenon.⁶⁸

Part of the MHCA's own aims, in line with the constitution and the avoidance of stigma and discrimination, include a more integrated approach to mental health care provision.⁶⁹ Mental health treatment should be made part of the general health care system as much as possible, and an emphasis should be placed upon community care rather than institutionalisation.⁷⁰ At the same time, however, specialised services and institutions should be available and inpatient treatment should be administered where truly appropriate.⁷¹

It is suggested that the problem of revolving door syndrome, most likely an unintended consequence of the provisions of the MHCA, has ended up undermining the MHCA's own aims as well as those of the constitution. Its effect may, however, be mitigated by placing a greater emphasis on the aim of achieving a more integrated mental health care system, as envisioned in the Act, and reserving inpatient treatment only for cases where there is no other viable option. Furthermore, refusal of voluntary treatment could probably be reduced to an extent

reconcile with deontological ideals and the idea that what is "right" ought to take priority over what is "good" – see also Currie I & de Waal J (2013) *The Bill of Rights Handbook* 6th Ed151.

⁶⁷ Behr *et al* (2002) *South African Journal of Psychiatry* 72.

⁶⁸ R Macfarlane, personal communication, 16 September 2014.

⁶⁹ Freeman (2002) *African Journal of Psychiatry* 7. This accords with international standards – see World Health Organisation *Integrating mental health services into primary health care* available at http://www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf (accessed 9 September 2014).

⁷⁰ Freeman (2002) *African Journal of Psychiatry* 7.

⁷¹ Freeman (2002) *African Journal of Psychiatry* 7.

if mental health users were handled according to the same ethical standards as any other patient, and with respect, dignity and sensitivity in the first place.⁷²

5.9 Provision of mental health treatment in terms of the National Health Act 61 of 2003

There is good authority to support the notion that, together with the provisions of the MHCA, provisions of the National Health Act may in certain instances also apply to mental health care users.⁷³

Section 1 of the National Health Act defines a health “user” as:

...a person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is... incapable of taking decisions, the definition includes the person’s spouse or partner, or parent, grandparent, adult child or brother or sister, or other authorised person.

This definition does not expressly exclude a mental health care user.

The term “unable” is not defined in the National Health Act, and so it remains a factual question.⁷⁴ The user’s “inability” to give informed consent may well be due to factors such as unconsciousness, intoxication, delirium, trance, shock or coma,⁷⁵ but the National Health Act does not cite a closed list of causes of this inability and

⁷² Moosa & Jeenah (2008) *African Journal of Psychiatry* 111.

⁷³ Carstens & Pearmain 901; McQuoid-Mason & Dada 100. In terms of S(2) of the MHCA any provision of the National Health Act or other legislation, other than the CRSA, which is in conflict with the MHCA will not apply to mental health care users.

⁷⁴ Nöthling Slabbert 72.

⁷⁵ Carstens & Pearmain 899.

there is nothing in the Act to suggest that an inability resulting from mental illness should be excluded from the provision.

In terms of sections 7(1) and 8 of the Act, proxy consent may be obtained in the case of a user who is “unable” to give informed consent to treatment. Section 7(1) provides that as long as the user’s right to participate in health-related decisions is ensured as meant in section 8, consent to health services may be provided on behalf of the user by someone else on the user’s behalf. The proxy consent may be given by someone mandated by the user in writing; someone who is authorised in terms of a law or court order (usually a *curator* of the user),⁷⁶ or if no-one has been mandated or appointed, the user’s spouse or partner, parent, grandparent, adult child, brother or sister of the user, in that particular order of preference.⁷⁷

Section 7 of the National Health Act further provides for emergency treatment in the event that a patient is unable to give informed consent. Section 7(1)(d)-(e) of the Act sanctions treatment of users in the absence of informed consent where the failure to treat the user, or a group of people which includes the user, will result in a serious risk to public health, or if a delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.⁷⁸

5.10 Conclusion

This chapter has sought to provide a short description of the influence of the MHCA on informed consent by mentally ill persons. More particularly, it has aimed to

⁷⁶ Proxy consent in terms of the National Health Act offers a preferable alternative to the appointment of a *curator personam* common law still allows for the appointment of a *curator personam*, but this involves High Court procedures and the associated cost implications – see *Ex parte Dixie*-case; Strauss (1984) 34.

⁷⁷ S7(1)(a)-(b) of the National Health Act; par 9.3-9.4 of the HPCSA *Guidelines on seeking patients’ informed consent*; McQuoid-Mason D & Dada M (2011) *A-Z of medical law* 97.

⁷⁸ Also McQuoid-Mason & Dada 97.

illustrate that although the MHCA's informed consent provisions are in line with international guidelines, there are several technical difficulties and uncertainties that remain to be addressed.

An overview was given of the MHCA's provisions regarding consent to treatment. It was shown that mental health care users, as a rule, have the right to consent to mental health treatment, and that they may not be provided with mental health treatment without informed consent unless authorised in terms of section 9(1)(b) of the MHCA, or if a psychiatric emergency situation as meant in section 9(1)(c) of the MHCA exists.

The procedures for voluntary-, assisted- and involuntary mental health treatment were discussed, with reference to the different circumstances under which each form of treatment would be appropriate, as well as the different administrative procedures to be followed for each type of treatment. It was made clear that the more restrictive the treatment category, the more stringent the MHCA's procedural requirements are, with involuntary mental health treatment having the most strict requirements.

Review procedures, periodical reviews and appeal procedures were then discussed, as was the "revolving door syndrome", a practical problem and perhaps an unintended consequence of the fact that an assisted- or involuntary user who regains consent-giving capacity may not be provided with further mental health treatment without informed consent. Finally, the possibility of concurrent application of the National Health Act's provisions governing consent and treatment-provision without informed consent, to the psychiatric context was discussed. It was submitted that the National Health Act should apply to mental health care users insofar as its provisions are not in conflict with those of the MHCA.

Chapter 6

Clinical aspects of informed consent in the context of the Mental Health Care Act 17 of 2002

Clinicians and lawyers are like long-married couples that still struggle to understand each other despite their mutual dependence.¹

6.1 Introduction

Psychiatry and the law are sometimes appropriately described as an “imperfect fit”.² In contexts such as psycho-legal assessment for purposes of the Mental Health Care Act (the “MHCA”),³ the two professions are brought together and differences in interpretation of common terms could increase the risk of misunderstanding and subsequent ill-considered legal decisions and undesirable consequences for the psychiatric patient.⁴

¹ Kaliski S ‘Introduction’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 1 at 1.

² American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders 5th Edition* (hereafter “DSM-5”) 25.

³ 17 of 2002, as amended (the “MCHA”). Like other legislation and legal contexts, the MHCA brings the professions of psychiatry and law closely together – Landman AA & Landman WJ (2014) *A practitioner’s guide to the Mental Health Care Act* 14.

⁴ Swanepoel M *Law, psychiatry and psychology: a selection of constitutional, medico-legal and liability issues* (unpublished LLD dissertation) UNISA (2009) 121. Interpretation difficulties are further complicated by human resource- and infrastructure issues – Moosa MYH & Jeenah FY ‘Involuntary treatment of psychiatric patients in South Africa’ (2008) 11 *African Journal of Psychiatry* 109 at 110.

This chapter seeks to demystify some of the confusion surrounding the role and significance of psychiatric concepts within the legal mental health framework, with specific reference to informed consent provisions of the MHCA. Definitions and concepts that are of relevance in this regard include mental illness, mental capacity and dangerousness.

The chapter will begin by exploring the legal- and clinical concepts of “mental illness”. Beginning with the MHCA’s definition of “mental illness”, the main focus of the discussion will be on clinical definitions of the concept and on the DSM- and ICD systems of classification and diagnosis of mental illness. Reference will be made to the legal validity and utility of the DSM-5.

Various aspects regarding mental capacity will then be discussed, including the general rule regarding capacity, the impact of mental illness on capacity, ethical approaches to capacity, degrees of impairment, specificity of capacity and capacity fluctuations over time. This will include an exposition of the clinical assessment of mental capacity, with reference to different methods of assessing mental competence typically employed in practice. The chapter will conclude with a brief discussion of the clinical assessment of risk of harm to self or others, focusing on suicide risk and dangerousness, including both risk of violence and homicide risk.

6.2 Mental illness

Perhaps inevitably, any legal definition of mental illness lends itself to over-simplification.⁵ Ideally though, legal definitions of mental illness should not to deviate too far from the views held in the psychiatric field.⁶

6.2.1 Section 1 of the MHCA

“Mental illness” for purposes of the MHCA means:⁷

...a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis.⁸

Related to mental illness, and of relevance for purposes of clinical assessments in terms of chapter V of the Act, section 1 also includes a definition for “mental health status”, being:

...the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis.⁹

⁵ Strauss SA (1991) *Doctor, patient and the law: a selection of practical issues* 3rd Ed 123.

⁶ Strauss (1991) 123.

⁷ Other legislative provisions, such as the S1 of the Children’s Act 38 of 2005, define mental illness by simply making reference to the MHCA’s definition.

⁸ S1(xx) of the MHCA. It is unclear what the legislature meant by being “authorised” to make a diagnosis, but it bears mentioning that the standard of psycho-legal training is deficient in South Africa. Improvement of the training and regulation processes should in itself serve to minimise inconsistent or illogical legal decisions based on ill-considered or poorly constructed expert assessments and opinions. See Kaliski 1-2; Kaliski S ‘Appendix: mental health practitioners: training issues’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 377 at 382.

⁹ S1(xx) of the MHCA.

Although they ensure that a qualified practitioner makes the diagnosis and that only relevant factors are taken into account,¹⁰ these definitions as such do not offer a full, in-depth description as to what is meant by mental illness.

The MHCA provides no specific guidelines regarding how psychiatric assessment should be done, aside from stating that the minister of health may promulgate regulations to prescribe an accepted methodology for this purpose.¹¹ The minister has not yet promulgated such regulations and the general consensus seems to be that the internationally accepted standards of psychiatric diagnosis,¹² are ICD-10 and the DSM-5.¹³

6.2.2 Defining the threshold of “normality”: clinical definitions of mental illness

Clinical definitions of mental illness are more complex and varied than those found in law. This is hardly surprising, considering that mental health care practitioners consider the question of mental illness from a very different and probably more detailed perspective than do legal practitioners.

Much of the problem in defining mental illness lies in defining the limits between “normality” and pathological states. At some point during their lives, it is probably safe to say that most people have felt worried or sad, or have behaved irrationally or in a way that was somehow “out of character”. Experts say that phenomena like hallucinations occur among the non-psychiatrically ill population on a regular basis,

¹⁰ S12(1) & 12(2) of the MHCA.

¹¹ S66(1)(a) & (b) & S67(2) of the MHCA; Landman & Landman 5.

¹² The use of internationally accepted guidelines for psychiatric assessment is recommended by principle 4(1) of the UN Principles and principle 3 of the WHO Principles.

¹³ Landman & Landman 5.

without causing marked distress.¹⁴ The question of when and whether fluctuations in mood or behaviour, or the manifestation of symptoms become diagnosable as mental illness is not necessarily a straightforward one.

Unlike physical illness, no standard set of tests has (at least not as yet) been developed which one might administer in order to confirm a psychiatric diagnosis.¹⁵ And, unlike physical disease, it is difficult to imagine a state of perfect mental health against which to measure mental abnormality.¹⁶ One could instead consider mental illness as a deviation from an average standard – but even then, how would one know where to draw the line in terms of exactly how much deviation signified mental illness, and how much merely implied eccentricity?¹⁷

Still many textbook-definitions of mental illness exist, the diversity of which speaks to the evasiveness of an all-encompassing description of the entity.¹⁸ Some of these definitions are founded on the model traditionally used to characterise physical illness, referring to pathology, symptom presentation, deviance and aetiology.¹⁹ For example:

¹⁴ Kaliski S 'Will forensic psychiatry survive DSM-5?' (2012) 15 *African Journal of Psychiatry* 13 at 13.

¹⁵ Thomas Insel, currently director of the United States National Institute of Mental Health ("NIMH"), aims to develop a new system of psychiatric diagnosis and classification which is based on genetics, biological markers and other scientific, physically measurable criteria rather than symptom clusters – Insel T (2013) "Transforming diagnosis" *National Institute of Mental Health Director's Blog*, web log post, 29 April 2013, available at <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml> (accessed 1 October 2014). While this could revolutionise psychiatric diagnosis and classification, it is perhaps unlikely to become standard practice in the immediate future.

¹⁶ Kruger A (1980) *Mental health law in South Africa* 49; Kaliski (2012) *African Journal of Psychiatry* 13.

¹⁷ Kruger 49-50.

¹⁸ Definitions tend to include words like "distress"; "dysfunction"; "disadvantage"; "disability"; "inflexibility"; "irrationality" and "statistical deviation", and while each of these suggests the presence of mental illness, they fail to depict psychopathology in its every guise. American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders 4th Edition Text Revision* (hereafter "DSM-IV-TR") xxx; Swanepoel (2009) LLD dissertation 108-109.

¹⁹ DSM-IV xxx; Stein D 'Psychiatric classification, stigma and mental health' (2013) *African Journal of Psychiatry* 227 at 227.

...a psychiatric illness or disease whose manifestations are primarily characterised by behavioral or psychological impairment of function, measured in terms of deviation from some normative concept; associated with distress or disease, not just an expected response to a particular event or limited to relations between a person and society.²⁰

Other definitions are minimalistic and practical, for example that of the World Health Organisation (the WHO), which defines mental illness as:

...a broad range of problems, with different symptoms... generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, mental retardation and disorders due to drug abuse. Most of these disorders can be successfully treated.²¹

Some clinicians may prefer a holistic approach to evaluating mental illness – and mental health. Such an approach would evaluate disturbances in the person's physical-;²² social-; emotional-; spiritual- and psychological (intellectual) dimensions of functioning.²³

In line with the MHCA's definition of "mental illness", clinicians may use a system of classification and diagnosis at the hand of which to define and diagnose mental illness. Although mental illness does not lend itself to easy categorization,²⁴ these

²⁰ Sadock BJ, Sadock VA & Ruiz P (eds) (2009) *Kaplan & Sadock's Comprehensive textbook of psychiatry 9th Edition Volume I* 925.

²¹ World Health Organization (2014) *Mental disorders* available at http://www.who.int/topics/mental_disorders/en/ (accessed 1 October 2014).

²² These conditions would formerly be listed on Axis III of the DSM-IV-TR – D Meeko, personal communication, 21 January 2015.

²³ I am indebted to Dr D Meeko, who explained this approach to me.

²⁴ Swanepoel (2009) LLD dissertation 91; Kaliski (2012) *African Journal of Psychiatry* 13, where the author suggests that instead of viewing mental illnesses as fitting into neat categories, they should be viewed in terms of a continuum, with conditions "flowing into one another".

systems remain an integral part of psychiatric tradition and practice.²⁵ South African mental health care professionals generally acknowledge the DSM- and ICD systems.²⁶ These are subsequently discussed in further detail.

6.2.3 The DSM and ICD: diagnosis and classification of mental illness

DSM-IV-TR and DSM-5

The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (the “DSM”), by the American Psychiatric Association (the “APA”) was released fairly recently,²⁷ replacing the DSM-IV-TR. The DSM-5 defines mental disorder as a disturbance which is listed in section II of the manual, and which meets the following general definition:²⁸

A mental disorder is a syndrome characterised by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior (*sic*) that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (*sic*) (e.g., political, religious, or sexual) and conflicts that are primarily between the

²⁵ Psychiatric classification is found as early as the fifth century BC, with Hippocrates’ differentiation of “mania” and “hysteria” – Sadock BJ & Sadock VA (2007) *Kaplan & Sadock’s Synopsis of psychiatry 10th Ed* 284. See also Burns JK & Alonso-Betancourt O ‘Are we slaves to DSM? A South African perspective’ (2013) 16 *African Journal of Psychiatry* 151 at 151.

²⁶ Allan A ‘Psychiatric diagnosis in legal settings’ (2005) 11 *South African Journal of Psychiatry* 52 at 52; Landman & Landman 5.

²⁷ DSM-5 was released during May 2013 – see American Psychiatric Association (2014) *DSM-5 development*, available at <http://www.dsm5.org/Pages/Default.aspx> (accessed 7 August 2013).

²⁸ DSM-5 20. “Medication-Induced Movement Disorders and Other Adverse Effects of Medication” and “Other Conditions That May Be a Focus of Clinical Attention” need not comply with the definition of mental disorder, as they are not considered mental disorders in terms of DSM-5. They have been included in section II by virtue of their ubiquity in the mental health care environment - DSM-5 22.

individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.²⁹

Section II of DSM-5 formally divides mental disorders into twenty-two categories.³⁰ A descriptive approach is followed throughout section II, systematically describing the key characteristics and features of each listed mental disorder.³¹ The manual avoids hypothesising about the cause of listed disorders.³²

Systems of classification are limited by the tendency of mental disorders to overlap instead of fitting into precise categories.³³ For this reason, DSM-5 cautions against using the lists of criteria in section II as if they were a simple diagnostic checklist or a “recipe book”,³⁴ and emphasises the importance of sound clinical judgement in making the final psychiatric diagnosis.³⁵ Some of the most relevant categories of mental disorder for purposes of this study, including changes made from the DSM-IV-TR to the DSM-5, where applicable, include:³⁶

²⁹ DSM-5 20.

³⁰ As listed in DSM-5 31-715.

³¹ Sadock & Sadock 28; DSM-5 21.

³² DSM-5 21.

³³ DSM-5 20.

³⁴ Kaliski (2012) *African Journal of Psychiatry* 13.

³⁵ DSM-5 19, 21.

³⁶ Another major change to the manual, which is perhaps an effort at harmonisation with the ICD-11, was the replacement of the multi-axial system with a new system of notation of diagnoses. Clinical disorders, personality disorders and mental retardation (termed “intellectual disability” or “intellectual developmental disorder” in DSM-5 - see DSM-5 809) and general medical conditions (former Axis I, -II and -III conditions respectively) are now documented together; psychosocial- and environmental problems (previously Axis IV) are documented with reference to the ICD-10’s “Z”-codes and impairment in functioning (previously Axis V) is documented with reference to the WHO’s Disability Assessment Schedule (WHO DAS 2.0) instead of the Global Assessment of Functioning (“GAF”) score. See Allgulander C ‘Understanding DSM-5: advice for South African practitioners’ (2013) 16 *African Journal of Psychiatry* 321 at 321; DSM-IV 16, 27; Sadock & Sadock 306. The WHO DAS 2.0 is available electronically at World Health Organization (2014) *WHO Disability Assessment Schedule 2.0 (WHO DAS 2.0)*, <http://www.who.int/classifications/icf/whodasii/en/> (accessed 1 October 2014).

- Schizophrenia spectrum and other psychotic disorders. DSM-5 diagnostic criteria for schizophrenia have been changed, and the disorder is no longer divided into subtypes.³⁷
- Bipolar and related disorders. The diagnostic criteria for bipolar disorder have been lowered.³⁸
- Depressive disorders. Major depressive disorder now includes grief after the death of a loved one, doing away with the former “bereavement exclusion”.³⁹
- Substance-related and addictive disorders. Former DSM-IV-TR concepts “substance dependence” and “substance abuse” have been replaced with the umbrella term of “substance use disorders” which vary between mild, moderate and severe in intensity.⁴⁰ This could have the unintended effect of grouping first-time substance users together with “hard-core addicts”, resulting in undue stigma and disregard for different treatment needs and prognoses.⁴¹
- Neurocognitive disorders. The new entity of “mild neurocognitive disorder”, which refers to a lesser degree of cognitive impairment much like the forgetfulness associated with more advanced age,⁴² is categorised here. More severe dementias, also grouped under neurocognitive disorder, are classified as “major neurocognitive disorder”.⁴³

³⁷ DSM-5 810.

³⁸ DSM-5 810.

³⁹ DSM-5 810-811.

⁴⁰ DSM-5 815.

⁴¹ Frances A (2012) “DSM-5 Is a Guide, Not a Bible: Simply Ignore Its 10 Worst Changes” *HuffPost*, web log post, 12 March 2012, available at www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html (accessed 16 July 2014) (hereafter referred to as Frances (2012) www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html).

⁴² It has been said that this typical forgetfulness of old age is both normal and incurable, and labelling its “sufferers” as mentally ill is likely to do more harm than good – Frances (2012) www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html.

⁴³ DSM-5 816.

- Personality disorders. DSM-IV criteria for personality disorders have remained unchanged for the time being.⁴⁴

ICD-10 and ICD-11

The ICD system was developed by the WHO,⁴⁵ and while the ICD-10 is still currently in use, the release of ICD-11 is anticipated shortly.⁴⁶ ICD-10 was accepted by the International Conference for the Tenth Revision of the International Classification of Diseases in 1989, and adopted in a resolution by the Forty-third World Health Assembly.⁴⁷

Unlike the DSM-5, the ICD-10 does not focus purely on mental disorders, but divides a large variety of health-related conditions into Chapters I-XXI, and assigns an alpha-numeric diagnostic code to each condition.⁴⁸

“Mental and Behavioural Disorders” are found at chapter V of the ICD-10 classification, and are coded F00-F99.⁴⁹ It follows a descriptive approach, with brief explanatory notes featuring throughout the classification.⁵⁰ The ICD-10 facilitates diagnosis by using “descriptive prototypes” of mental illnesses, rather than at the hand of the often-arbitrary checklists of diagnostic criteria of DSM.⁵¹

⁴⁴ DSM-5 816.

⁴⁵ *ICD-10 volume 1* 3; Sadock & Sadock 284.

⁴⁶ Release of ICD-11 is expected anytime from 2015 onwards – DSM-5 xli.

⁴⁷ *ICD-10 volume 1* 3; Sadock & Sadock 284.

⁴⁸ *ICD-10 volume 1* iii-iv, 2 & 13.

⁴⁹ *ICD-10 Version: 2010*, available at <http://apps.who.int/classifications/icd10/browse/2010/en> (accessed 1 July 2014).

⁵⁰ See throughout *ICD-10 volume 1*.

⁵¹ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

The ICD-10 proposes the following definition of mental disorder:⁵²

[A] mental disorder is a clinically recognisable collection of symptoms or behaviour associated in most cases with distress or interference with personal functions. A deviant pattern of behaviour, whether political, religious, or sexual, or a conflict between an individual and society, is not a mental disorder unless it is symptomatic of a dysfunction in the individual.

Some of the more relevant listed ICD-10 disorders for purposes of this study include the following:

- Organic mental disorders (F00-F09). This category includes mental disorders with aetiology involving biological or medical factors such as cerebral disease or brain injury.⁵³ They may be primary, involving the direct impact of physical illness on the brain, or secondary, where systemic disease affects the brain as well as other organs.⁵⁴ Dementia is included in this category.⁵⁵
- Mental and behavioural disorders due to psychoactive substance abuse (F10-F19).⁵⁶
- Schizophrenia, schizotypal and delusional disorders (F20-F29). This category includes schizophrenia, schizotypal disorder, persistent delusional disorder, and other acute and transient psychotic disorders and schizoaffective disorders.⁵⁷

⁵² Swanepoel (2009) LLD dissertation 109.

⁵³ *ICD-10 volume 1* 312.

⁵⁴ *ICD-10 volume 1* 312.

⁵⁵ *ICD-10 volume 1* 312.

⁵⁶ *ICD-10 volume 1* 320.

⁵⁷ *ICD-10 volume 1* 325.

- Affective (mood-) disorders (F30-F39). These involve episodes of depression, elation, and abnormal changes in activity, and are often associated with stressful life circumstances.⁵⁸
- Personality- and behaviour disorders in adults (F60-F69). These disorders are characterised by persistent disturbance in how the sufferer copes with daily life, his social behaviours, his way of life and overall experiences.⁵⁹ There is usually a subjective sense of distress and poor social performance.⁶⁰

6.2.4 Mental illness or medical illness?

Tell me where is fancy bred,
Or in the heart or in the head?⁶¹

The definitions and classifications of mental disorders reveal an ambivalence surrounding the physical- and psychological aspects of psychiatric conditions. For example, the ICD-10 classifies some psychiatric conditions as organic, and others as non-organic.⁶² Ironically, the APA criticises its own use of the phrase “mental illness” in the DSM, stating that it amounts to “reductionistic anachronism of mind/body dualism”.⁶³

⁵⁸ *ICD-10 volume 1* 332.

⁵⁹ *ICD-10 volume 1* 358-359; Swanepoel (2009) LLD dissertation 92.

⁶⁰ *ICD-10 volume 1* 358-359.

⁶¹ From Shakespeare *W The merchant of Venice* (Verity AW ed) (1958) Act III Scene II 63.

⁶² Dementia and behavioural disorders due to psychoactive substance abuse for instance, are considered “organic”.

⁶³ The DSM-IV-TR contained the same contradiction – DSM-IV xxx.

Determining whether the cause of psychiatric symptoms relates to mental illness, medical illness, or both, is an important part of emergency psychiatric evaluation.⁶⁴ Accurate differentiation can assist in providing timely and appropriate treatment.⁶⁵

The distinction can furthermore have legal implications. Section 34 of the MHCA has been interpreted as requiring the presence or reasonable suspicion of “mental illness” involuntary mental health treatment.⁶⁶ It has been proposed that if the 72-hour observation reveals a medical condition as cause of psychiatric symptoms,⁶⁷ the user could be precluded from receiving involuntary mental health care in accordance with the Act.⁶⁸

Much of the challenge in distinguishing between mental- and physical disorders relates to the duality of body and mind. Science has evolved to discover that mental disorder often involves an interaction of exogenous and endogenous factors.⁶⁹ indeed there is “much ‘physical’ in ‘mental disorders’ and much ‘mental’ in ‘physical disorders’”.⁷⁰

Some medical conditions have been known to produce symptoms similar to those of psychiatric conditions, for example diabetes; thyroid disease; intoxication and withdrawal; HIV/AIDS and head trauma.⁷¹ Substance-related problems can be particularly difficult to classify as either “medical-” or “mental” conditions. Acute intoxication might not technically constitute mental illness, while a state of

⁶⁴ Sadock & Sadock 909.

⁶⁵ Sadock & Sadock 909.

⁶⁶ Moosa & Jeenah (2008) *African Journal of Psychiatry* 110.

⁶⁷ Moosa & Jeenah (2008) *African Journal of Psychiatry* 110. The 72-hour observation can aid the diagnosis of mental health related conditions by providing the opportunity for medical conditions to stabilise.

⁶⁸ Moosa & Jeenah (2008) *African Journal of Psychiatry* 110. The situation should then be governed by the provisions of the National Health Act 61 of 2003 and not primarily by those of the MHCA.

⁶⁹ R Macfarlane, personal communication, 16 September 2014.

⁷⁰ DSM-IV-TR xxx; Sadock & Sadock 319.

⁷¹ Sadock & Sadock 909.

withdrawal may well render a user mentally ill,⁷² as may the effects of (particularly long-term) substance use.⁷³ In clinical terms intoxication could be seen as a type of “transient form” of mental disorder, which follows from alterations in brain physiology.⁷⁴ An overwhelming majority of involuntary mental health care users, at least in the Gauteng province, present with a diagnosis of substance-induced psychosis.⁷⁵ These patients are regarded as mentally ill for purposes of the MHCA.

The question of the physical- and psychological factors involved in the genesis of mental disorder remain, to a large extent, unresolved.⁷⁶ Are the mind and the body two separate entities?⁷⁷ Is there no such thing at all as mental “illness”, with disease being found only in the body and “mental illnesses” being nothing but “personal, social and ethical problems in living”?⁷⁸ Should mind and body be viewed as a single entity?⁷⁹ Or are the mind and body among several other “extricates” of a primary entity, namely the person, with which psychiatry is concerned?⁸⁰ A full exploration of these issues falls outside the ambit of this study. For present purposes it is sufficient to state that the term “mental illness” may well be obsolete.

⁷² Panieri Peter L ‘The effects of alcohol and substances’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 126 at 130.

⁷³ Dementia, peripheral neuropathy, pellagra, Wernicke’s encephalopathy, alcohol-induced persisting amnesic disorder (Korsakoff’s syndrome) and delirium tremens are known to result from long-term excessive alcohol use – Panieri Peter 130-136. Cocaine, opioids, phencyclidine (PCP) have been associated with delirium, gasoline and atropine with dementia, and marijuana and diazepam with amnesia – Sadock & Sadock 319.

⁷⁴ R Macfarlane, personal communication, 16 September 2014.

⁷⁵ M Swanepoel, personal communication, 21 January 2015.

⁷⁶ R Macfarlane, personal communication, 16 September 2014.

⁷⁷ In accordance with dualism, a paradigm advanced by René Descartes – Van Staden (2006) *South African Psychiatry Review* 93.

⁷⁸ As averred by Szasz TS (1972) *The myth of mental illness: foundations of a theory of personal conduct* 269.

⁷⁹ As the monist view proposes – Van Staden (2006) *South African Psychiatry Review* 93.

⁸⁰ In accordance with the pluralist approach – Van Staden (2006) *South African Psychiatry Review* 95.

6.2.5 Validity and utility of diagnostic systems: has the DSM-5 gone too far?

Clinical psychiatric thresholds already present uncertainty and their forensic validity, utility and overall credibility may be called into question if psychiatric diagnostic systems continue arbitrarily changing the legal threshold for mental illness.⁸¹ The validity of psychiatric diagnoses has come into the crossfire once again with the release of the DSM-5,⁸² begging the question as to whether the manual should still be acknowledged as a system of “accepted diagnostic criteria” for purposes of the MHCA.

The implications of legal decisions based upon psychiatric classifications and diagnoses are far-reaching and it would be unwise of judicial bodies, including courts and administrative bodies such as Mental Health Review Boards, to acknowledge scientific phenomena which have not gained at least “face validity” within the scientific field.⁸³

A basic test of validity of scientific constructs, which resonates in section 1 of the MHCA, may be found in the case of *Frye v United States*.⁸⁴ The test decides the legal validity of a scientific construct based on whether it has gained “general acceptance” in its field of expertise.⁸⁵ Since courts – and administrative judicial bodies – are not primarily tasked with conducting scientific research, it would be

⁸¹ Kaliski (2012) *African Journal of Psychiatry* 13. See also case law such as *R v Von Zell* 1953 (3) SA 303 (A) at 311 A-B, where psychiatry is called “...an empirical and speculative science with rather elastic notation and terminology, which is usually wise after the event”. Also Kaliski S ‘Will forensic psychiatry survive DSM-5?’ (2012) 15 *African Journal of Psychiatry* 13 at 13.

⁸² Allan (2005) *South African Journal of Psychiatry* 53.

⁸³ Allan (2005) *South African Journal of Psychiatry* 52.

⁸⁴ 293 F. 1013 (D.C. Cir. 1923); Allan (2005) *South African Journal of Psychiatry* 50.

⁸⁵ Allan (2005) *South African Journal of Psychiatry* 52-53; Swanepoel (2009) LLD dissertation 123.

unwise of them to acknowledge scientific phenomena which have not gained at least this acknowledgement.⁸⁶

In addition to the “general acceptance” test in *Frye*, the case of *Daubert v Merrell Dow Pharmaceuticals Inc.*⁸⁷ suggests that the judiciary further takes into account whether a construct can and has been tested; the extent of peer review and publication and the known or possible error rate in order to gauge its legal validity.⁸⁸ These criteria have not been specifically incorporated into South African law, but may nevertheless serve as useful guidelines.⁸⁹

The DSM has been part of South African “psychiatric tradition” for a significant length of time.⁹⁰ Whether its validity is truly still generally accepted among practitioners is another matter: there are several objections to the DSM-5 that beg the question of whether the APA has not perhaps taken the amendments to the manual too far.

Whereas the DSM-IV-TR already had an inherent tentativeness about it,⁹¹ the DSM-5 has been subject to such controversy as might, considering the four criteria

⁸⁶ Some opine that inclusion in the ICD- and/or DSM system is enough to imply general acceptance, but again, if the system’s validity is called into question, then its diagnoses cannot claim validity based simply on inclusion in a flawed system. Allan (2005) *South African Journal of Psychiatry* 52.

⁸⁷ 113 S. Ct. 2786 (1993).

⁸⁸ Allan (2005) *South African Journal of Psychiatry* 53; Swanepoel (2009) LLD dissertation 123. The testing and error rate insofar as psychiatric diagnoses are concerned, may be said to refer to the descriptive validity, diagnostic validity and predictive validity (prognostic accuracy) thereof, and reliability to diagnostic reliability (consistency) as well as causal relationships and treatment efficacy – Allan (2005) *South African Journal of Psychiatry* 53-54.

⁸⁹ The criteria should still serve as useful interpretative guidelines, most notably in terms of S39(1) of the Constitution of the Republic of South Africa (the “CRSA”). Even though the criteria may have been used indirectly in reported South African case law as averred by Allan (2005) *South African Journal of Psychiatry* 52, it is submitted that Mental Health Review Boards are not bound by the usual system of precedents because they are *quasi-judicial* administrative tribunals, and not courts of law.

⁹⁰ Allan (2005) *South African Journal of Psychiatry* 52-53; Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

⁹¹ Allan (2005) *South African Journal of Psychiatry* 53.

mentioned above, undermine its validity and utility in the legal context. Some of the reasons for the harsh criticism against and rejection of the DSM-5 include:⁹²

- Safety and ethical aspects.⁹³ DSM-5 “pathologises” common, expectable human behaviours and reactions, leading to unnecessary stigma, over-medicalization, over-medication, and potential misuse of changed diagnostic labels.⁹⁴

[P]eople with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and ‘behavioural addictions’ will soon be mislabelled as psychiatrically sick and given inappropriate treatment.⁹⁵

- Conflicting interests and monetary gain.⁹⁶ The interests of institutions are reportedly promoted by DSM-5 at the cost of patient welfare, with many DSM-5 Taskforce members reportedly being affiliated with pharmaceutical companies.⁹⁷
- Field trials for DSM-5 were done at hospitals and in routine clinical practice,⁹⁸ but the tests did not include all DSM-5 disorders.⁹⁹ The lack of completed field testing before publication of DSM-5 was reportedly due to financial pressures.¹⁰⁰

⁹² Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 151.

⁹³ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

⁹⁴ Frances (2012) www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html.

⁹⁵ Frances (2012) www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html. The DSM-5 has been accused of contributing to nonsensical- or “fad” diagnoses.

⁹⁶ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

⁹⁷ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 151.

⁹⁸ DSM-5 7-8.

⁹⁹ DSM-5 10 – only “most” disorders were included in the trials.

¹⁰⁰ Frances (2012) www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html.

Public-, professional- and expert review of the DSM-5 were provided for,¹⁰¹ but have, like the field trials, been criticised as being “deeply flawed”.¹⁰²

The ICD has not been subject to the same heated debate as its counterpart, and may well be said to enjoy a greater degree of general acceptance and overall validity than the DSM.¹⁰³ This is evidenced by:¹⁰⁴

- Global use and credibility. ICD-10 is used by some 194 WHO member states, including South Africa.¹⁰⁵ It is available in several languages. Significantly fewer countries make use of DSM-5.¹⁰⁶
- ICD-10 is the accepted and mandatory system for diagnostic coding in South African public and private health care sectors,¹⁰⁷ while nothing obliges a practitioner to use the DSM.¹⁰⁸
- ICD-10 has not been faced with suspicions of perverse financial incentives, conflicting interests or other unethical conduct.¹⁰⁹

¹⁰¹ DSM-5 xliii, 8-10; Stein (2013) *African Journal of Psychiatry* 227. Comments could be made on the webpage www.dsm5.org.

¹⁰² Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 151. The APA reportedly failed to heed suggestions raised on its webpage and issues raised in an open letter to the APA, hence falling short of basic accepted peer review standards - A copy of the *Open Letter to the DSM-5* is available at <http://www.ipetitions.com/petition/dsm5/> (accessed 6 June 2014).

¹⁰³ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

¹⁰⁴ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153-155.

¹⁰⁵ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153; World Health Organization (2014) *Countries*, available at <http://www.who.int/countries/en/> (accessed 5 September 2014).

¹⁰⁶ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153; also Stein DJ ‘Psychiatric classification, stigma and mental health’ (2013) 16 *African Journal of Psychiatry* 227 at 227.

¹⁰⁷ S59(1) read with Regulation 5(f) of the Regulations in Terms of the Medical Schemes Act 131 of 1998, published under Government Notice R1262 in *Government Gazette* 20556 of 20 October 1999 (as amended). See also Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

¹⁰⁸ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 155.

¹⁰⁹ Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 155.

- The ICD-10's extensive revision process between initiation in 1983 and acceptance in 1989 involved the input of several expert groups, committees and individual experts.¹¹⁰ Special meetings were held between 1984 and 1987 involving bodies such as the Expert Committee on the International Classification of Diseases – Tenth Revision.¹¹¹ The system is consultative and representative, and takes into account cultural differences worldwide.¹¹² The WHO took pains to collaborate with member states and Regional Offices and to incorporate many of the suggestions into the ICD-10.¹¹³ Objections relating to the ICD-10's testing and clinical trials are few and far between.

6.3 Mental capacity

We must secure the shadow
Ere the substance fades.¹¹⁴

Mental capacity can be a difficult concept to define and a difficult ability to accurately assess. Competency judgements serve to determine whether someone's wishes should be respected with regard to medical- and mental health related decisions.¹¹⁵ The outcome of the assessment can have a significant impact on the patient's welfare and other interests and as such, there rests a great moral- and legal responsibility and a huge amount of trust upon the shoulders of the assessing practitioner.¹¹⁶

¹¹⁰ *ICD-10 Volume 1* 1.

¹¹¹ *ICD-10 Volume 1* 1.

¹¹² Burns & Alonso-Betancourt (2013) *African Journal of Psychiatry* 153.

¹¹³ *ICD-10 Volume 1* 1.

¹¹⁴ From Manson M (2003) '♣' *The Golden Age of Grotesque*.

¹¹⁵ Beauchamp TL & Childress JF (2001) *Principles of biomedical ethics 5th Ed* 69, who refer to the "gatekeeping function" of capacity determinations.

¹¹⁶ Kim SYH (2010) *Evaluation of capacity to consent to treatment and research* 3-4, 15.

In a moral sense capacity assessments are related to the principle of respect for autonomy. One might argue that if someone cannot act with sufficient autonomy in the first place (whether because they are immature, ignorant, under undue influence, irrationally suicidal, addicted to drugs or otherwise incapacitated), then there is no obligation to respect his (non-existent) autonomy.¹¹⁷ A person might act intentionally but not autonomously because his freedom of choice or understanding has been limited by some or other factor (such as ignorance, age or mental retardation), because he is irrational, or his judgement has become impaired due to mental illness or psychosis, severe depression, suicidality, or substance-related problems.¹¹⁸

The determination can be a difficult one to make. Morally there are two major pitfalls to avoid in making capacity determinations; the first being to wrongly overrule the wishes of a competent person, and the second to wrongly respect the wishes of one who lacks capacity as if they were in fact autonomous and possessed of decision-making capacity.¹¹⁹

Capacity assessment may be called for in a variety of legal contexts, including the instance where a psychiatric patient's capacity to consent to a medical procedure is being called into question.¹²⁰ Valid informed consent to medical treatment is largely dependent on the presupposition that the consent-giver, at the time of giving consent has (or had) both legal and factual mental capacity to do so,¹²¹ making

¹¹⁷ Beauchamp & Childress 65.

¹¹⁸ Beauchamp & Childress 65.

¹¹⁹ Berghmans RLP Widdershoven GAM 'Ethical perspectives on decision-making capacity and consent for treatment and research' (2003) 22 *Medicine and Law* 391 at 392.

¹²⁰ Zabow T & Kaliski S 'Ethical considerations' in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 357 at 371.

¹²¹ Van Oosten FFW *The doctrine of informed consent in medical law* (unpublished LLD thesis) UNISA (1989) 17, Neethling *et al* 106; McQuoid-Mason D & Dada M A – Z of *medical law* (2011) 93; Carstens PA & Pearmain DL (2007) *Foundational principles of South African medical law* 879.

capacity the “umbrella under which all other issues are dependent”.¹²² The prerequisite of mental capacity is probably the most likely to create difficulties in the psychiatric field.¹²³

6.3.1 Legal capacity and clinical capacity

The MHCA lacks a definition of decision-making capacity. In law generally, a person is considered to have mental capacity if he understands the nature and effect of what he is doing.¹²⁴ Legal capacity is relative to the circumstances, and depends on the legal rights or interests that will be affected, the seriousness of the potential harm, the complexity of the act to which consent is given, and so forth.¹²⁵

The legal determination of medical decision-making capacity is made at the hand of the patient’s ability to understand the nature and consequences of treatment and to reconcile him- or herself with the idea of undergoing it.¹²⁶ After having been duly informed, the patient should understand the reasons for and the consequences of the treatment, “as fully as an average person from the same culture with the same level of education”.¹²⁷

The fact that the MCHA is conspicuously silent about the intended legal meaning of decision-making “capacity” leaves the determination of decision-making capacity for purposes of the Act, almost entirely to the good judgement of mental health care practitioners - effectively obliterating the distinction between “legal capacity” and

¹²² Zabow T ‘Competence and decision-making: Ethics and clinical psychiatric practice’ (2008) 1 *South African Journal of Bioethics and Law* 61 at 61.

¹²³ Carstens & Pearmain 248.

¹²⁴ McQuoid-Mason & Dada 99.

¹²⁵ Van der Walt JC & Midgley JR (2005) *Principles of delict 3rd Edition* 144.

¹²⁶ Strauss (1984) 24.

¹²⁷ Dada MA & McQuoid-Mason DJ (eds) *Introduction to medico-legal practice* (2001) 103-104.

“clinical incapacity”.¹²⁸ A clinical determination of incapacity in essence becomes the equivalent of a legal one.¹²⁹

6.3.2 The general rule for decision-making capacity

As a rule, persons who have attained the age of majority (18 years of age)¹³⁰ are presumed to be legally and clinically possessed of the necessary mental capacity to give consent to medical treatment, unless it becomes apparent that some factor, such as unconsciousness, intoxication, delirium, trance, shock, coma,¹³¹ or indeed, mental illness, has adversely affected this capacity.¹³²

This holds true for mentally ill persons as well as other adults, a notion supported by sections 9 and 14 of the MCHA, dealing with consent by mentally ill persons to mental health treatment and intimate relationships, respectively.¹³³ It is further supported by Regulation 35,¹³⁴ which provides that all categories of mental health

¹²⁸ Moosa & Jeenah (2008) *African Journal of Psychiatry* 110; Zabow (2008) *South African Journal of Bioethics and Law* 62.

¹²⁹ Beauchamp & Childress 69. This can be problematic insofar as clinicians and legal practitioners' interpretations of mental capacity differ.

¹³⁰ In terms of S17 of the Children's Act 38 of 2005. This approach is open to critique in that it categorically regards persons under the age of 18 as being unable to give consent to treatment, merely on account of his age, whether he in actual fact has the intellectual maturity to give consent or not.

¹³¹ Carstens & Pearmain 899.

¹³² Carstens & Pearmain 900; Zabow (2008) *South African Journal of Bioethics and Law* 62-63; see also in this regard par 9.1 of the Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: Seeking patients' informed consent: The ethical considerations* available at http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf (accessed 2 September 2014) (hereafter the “HPCSA *Guidelines on seeking patients' informed consent*”); Landman & Landman 86.

¹³³ Carstens & Pearmain 900.

¹³⁴ Reg 35 contained in the General Regulations to the MHCA, published under GN R1467 in GG 27117 of 15 December 2004 as corrected by GN R98 in GG 27236 of 11 February 2005.

care user may consent to medical treatment not relating to his mental health treatment, provided he is capable of doing so.¹³⁵

It is the mental abilities of the patient, and not the mental illness he or she has been diagnosed with, which will be decisive in determining mental capacity.¹³⁶ The presence of mental illness *per se* does not amount to, nor justify any inference regarding, the sufferer's mental capacity, whether legally or clinically.¹³⁷ Even a severely mentally ill person could still have decision-making capacity,¹³⁸ and two persons diagnosed with the same mental illness under the same set of diagnostic criteria may have very different levels of functioning and decision-making abilities.¹³⁹

That being said, a diagnostic label is not entirely irrelevant to the determination of mental capacity. The fact remains that mental illness does have the tendency to "[strike] at the heart of the fundamental legal principle of capacity."¹⁴⁰ A psychiatric diagnosis may at the very least serve as a point of departure for the evaluation of mental capacity: the results of a psychiatric examination could be a lot more meaningful, for instance, when viewed in context of a diagnosis of Alzheimer's disease.¹⁴¹

Psychiatric illness will not affect all sufferers in the same way and each type of disorder is likely to present its own challenges with regard to mental incapacity.¹⁴² Different types of mental illness which may vary in terms of severity, including psychosis; mood disorders; traumatic brain injury; mental retardation; alcoholism,

¹³⁵ Carstens & Pearmain 900.

¹³⁶ Strauss (1984) 34.

¹³⁷ Carstens & Pearmain 900-901; Burchell 275, 280; Kaliski (2012) *African Journal of Psychiatry* 13; DSM-5 25.

¹³⁸ Dada & McQuoid-Mason 104.

¹³⁹ Swanepoel (2009) LLD dissertation 122.

¹⁴⁰ Carstens & Pearmain 248.

¹⁴¹ Potocnik F & Pienaar W 'The Elderly' *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 721 at 275.

¹⁴² Beauchamp & Childress 71.

and other substance-related disorders, are likely to result in varying degrees of mental incapacity.¹⁴³ The degree of impairment must be evaluated for each individual with regard to the nature of the mental disorder and the task concerned.¹⁴⁴ Personality disorders offer a good illustrative example, in that some of the sub-types are associated with more impulsivity and anger than is considered “normal”, which may in turn affect the sufferer’s capacity to behave “normally” in some senses – but again, this can be difficult to evaluate.¹⁴⁵

6.3.3 Ethical approaches to mental capacity

Two divergent ethical approaches underlying mental capacity may be distinguished, namely the functional- and categorical approaches.¹⁴⁶

Categorical approach

In terms of the categorical ethical approach to capacity one is deemed mentally competent or not simply because one belongs to a particular category, for example that of voluntary- or involuntarily mental health care users.¹⁴⁷ It is a dichotomous approach which is not congruent with the factual reality that the nature and extent of mental incapacity due to mental disorder can be highly variable.¹⁴⁸ The categorical approach is typical of older mental health legislation, including the Mental Health Act 18 of 1973, in terms of which being mentally ill generally meant being

¹⁴³ Beauchamp & Childress 71; Kim 40-54; Zabow ‘The Mental Health Care Act (Act 17 of 2002)’ in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 58 at 59.

¹⁴⁴ R Macfarlane, personal communication, 16 September 2014.

¹⁴⁵ R Macfarlane, personal communication, 16 September 2014.

¹⁴⁶ Van Staden CW ‘Can involuntarily admitted patients give informed consent to participation in research?’ (2007) 13 *South African Journal of Psychiatry* 10 at 10.

¹⁴⁷ Van Staden (2007) *South African Journal of Psychiatry* 10.

¹⁴⁸ Van Staden (2007) *South African Journal of Psychiatry* 11.

mentally incompetent, and that one could legally act on one's own behalf perhaps only during a *lucidum intervallum*.¹⁴⁹

Functional approach

In contrast to the categorical approach, the functional approach to capacity acknowledges the relative and variable nature of mental capacity, and the need to assess it clinically in relation to each specific task.¹⁵⁰ It enjoys support globally.¹⁵¹ This approach underlies the MHCA's provisions, as is particularly apparent in the provisions relating to consent to mental health treatment;¹⁵² intimate relationships;¹⁵³ and consent to general medical treatment.¹⁵⁴

6.3.4 Degrees of impairment

Capacity has been construed at the hand of different clinical- and legal definitions.¹⁵⁵ Theoretically, mental capacity is sometimes seen in terms of "standards of ability", which may range from the low end to the high end of mental abilities.¹⁵⁶

Standards of ability in turn suggest that, rather than being an absolute, varying degrees of capacity impairment may exist, depending on factors which are subsequently further discussed. The fact that, in criminal law, an accused can be

¹⁴⁹ Claassen & Verschoor 61; Van Staden (2007) *South African Journal of Psychiatry* 10-11.

¹⁵⁰ Van Staden (2007) *South African Journal of Psychiatry* 10.

¹⁵¹ Van Staden (2007) *South African Journal of Psychiatry* 10.

¹⁵² S9 of the MHCA.

¹⁵³ S14 of the MHCA.

¹⁵⁴ Reg 35 of the MHCA. Also Carstens & Pearmain 900; Van Staden (2007) *South African Journal of Psychiatry* 10-11.

¹⁵⁵ Beauchamp & Childress 70; Kim 4.

¹⁵⁶ Potocnik & Pienaar 274-275.

found “guilty but mentally ill”¹⁵⁷ in fact already indicates that the acknowledgement of degrees of incapacity is not an entirely new concept in South African law.¹⁵⁸

6.3.5 Specificity of mental capacity

Capacity in its most basic sense is “the ability to perform a task”.¹⁵⁹ Some authors distinguish general capacity, as the ability to handle “all one’s affairs” adequately, from specific competencies, which pertain to specific tasks.¹⁶⁰

Seeing as capacity determinations normally only focus on a specific task or to a limited range of tasks, it is best to view mental capacity as specific rather than global.¹⁶¹ This would also be fair towards mental health care users, who will seldom be completely incompetent,¹⁶² and are instead likely to have full capacity to perform some tasks, and be incapacitated in respect of others.¹⁶³

Because the performance of different acts requires different abilities, the test or criteria for the capacity to perform each task or act is also different from the next.¹⁶⁴ There are different sets of criteria for judging someone’s capacity to stand trial,

¹⁵⁷ Black DW & Andreasen NC (2011) *Introductory textbook of psychiatry 5th Ed* 474.

¹⁵⁸ Strauss (1991) 133; also *Mnyanda* at 764B & 766H-767G and *Lehnberg* generally. Both cases dealt with psychopathy (antisocial personality disorder) as “lesser degree” of mental illness which, while it might not render the sufferer criminally incapacitated, could possibly lead to diminished criminal capacity.

¹⁵⁹ Beauchamp & Childress 70.

¹⁶⁰ Gutheil TG & Appelbaum TS (1982) *Clinical handbook of psychiatry and the law* 215.

¹⁶¹ Beauchamp & Childress 70; Gutheil & Appelbaum 215.

¹⁶² Zabow (2008) *South African Journal of Bioethics and Law* 61.

¹⁶³ Beauchamp & Childress 70.

¹⁶⁴ Beauchamp & Childress 70; Zabow (2008) *South African Journal of Bioethics and Law* 61.

commit a crime, make a will, enter into a contract, raise dachshunds, lecture medicine or consent to medical treatment.¹⁶⁵

Regard should be had for the individual patient's abilities and needs in order to ensure that any infringement upon his (personal- or property-) rights is justified.¹⁶⁶

6.3.6 Capacity fluctuations over time

Decision-making capacity may fluctuate significantly over time and during the course of the mental illness.¹⁶⁷ Even a person who is severely mentally ill or one suffering from psychotic episodes may at times have the capacity for decision-making.¹⁶⁸

This situation complicates clinical capacity evaluations. Fluctuations in capacity may be as frequent as every hour.¹⁶⁹ The situation could be so extreme that an accurate capacity evaluation cannot be immediately carried out, in which case it is best to evaluate the patient's mental abilities over a longer period of time.¹⁷⁰

It might be useful to distinguish the type of underlying illness and whether the mental defect it causes is permanent or may be quickly reversed:¹⁷¹ some conditions cause long-term, progressive changes in cognitive function and others

¹⁶⁵ Beauchamp & Childress 70; Dada & McQuoid-Mason 107-109.

¹⁶⁶ Zabow 59.

¹⁶⁷ Beauchamp & Childress 70; Dada & McQuoid-Mason 104.

¹⁶⁸ Dada & McQuoid-Mason 104.

¹⁶⁹ Beauchamp & Childress 70.

¹⁷⁰ Beauchamp & Childress 70. Also S34 of the MHCA (the 72-hour assessment).

¹⁷¹ Beauchamp & Childress 70.

rapid fluctuations in mental abilities (transient ischemic attack, transient global amnesia).¹⁷²

6.3.7 Clinical capacity judgements: assessment methods in clinical practice

Most clinicians probably assess their patients' decision-making capacity every day on an informal basis without even realising it.¹⁷³ The assessment of mental capacity usually involves a clinical interview, which each practitioner may conduct according to his own methods.

The clinician might try to gauge whether the patient understands the facts of his present situation, and whether he thinks about these facts rationally.¹⁷⁴ A patient who can understand and process information relevant to the decision he is required to make, weigh up the pros and cons thereof and independently make a decision on the matter based on his own values and beliefs is probably possessed of mental capacity.¹⁷⁵ Since mental capacity has a known tendency to fluctuate over time though, it is ideal that the assessment thereof should be done at the time when the decision is to be made.¹⁷⁶

Sometimes it will be readily apparent during the interview that the person either possesses or lacks the capacity to make decisions, and in both cases intervention may be urgently needed.¹⁷⁷ Formal capacity assessment in these instances would

¹⁷² Beauchamp & Childress 70.

¹⁷³ Zabow (2008) *South African Journal of Bioethics and Law* 63.

¹⁷⁴ Zabow (2008) *South African Journal of Bioethics and Law* 62.

¹⁷⁵ Zabow (2008) *South African Journal of Bioethics and Law* 62.

¹⁷⁶ Beauchamp & Childress 70; Zabow (2008) *South African Journal of Bioethics and Law* 62.

¹⁷⁷ Zabow (2008) *South African Journal of Bioethics and Law* 62; R Macfarlane, personal communication, 16 September 2014.

accordingly be unnecessary, and even ill-advised.¹⁷⁸ In some circumstances the patient's mental state has deteriorated to the extent that he is completely unaware of his surroundings or of the fact that he is ill.¹⁷⁹ He might not be able to give an account of the events that led to his assessment, or know why is there in the first place.¹⁸⁰ It is common to obtain collateral information and not unusual to rely mostly on this during assessment if the case is of such severity.¹⁸¹

More formal assessments may be called for when there is uncertainty about a person's capacity for decision-making. No widely accepted curriculum is presently in use for teaching clinicians how to go about this task,¹⁸² and at best they are directed by professional guidelines to "consult the guidance issued by the relevant professional bodies".¹⁸³

Guidelines that can be taken into account during assessment include variables such as the patient's age, language, culture, level of literacy, consultation time available for assessment and the responsibility the patient has to provide information.¹⁸⁴ Each of these factors could limit the patient's ability to understand and communicate information, which in turn could inappropriately lead to a finding of impaired mental capacity.¹⁸⁵ As far as possible the interview and assessment should be done with sensitivity to culture and cultural norms, in a comfortable environment and in the

¹⁷⁸ R Macfarlane, personal communication, 16 September 2014.

¹⁷⁹ SA Amos, personal communication, 21 January 2015.

¹⁸⁰ SA Amos, personal communication, 21 January 2015.

¹⁸¹ D Meeko, personal communication, 21 January 2015.

¹⁸² Janse van Rensburg ABR 'A framework for current public mental health care practice in South Africa' (2007) 10 *African Journal of Psychiatry* 205 at 207; Kim 4.

¹⁸³ Par 9.3 of the HPCSA *Guidelines on seeking patients' informed consent*. Par 9.2 thereof determines that assessment is usually indicated if a patient's choice is irrational and steps have been taken to make sure that the patient's information needs have been adequately met.

¹⁸⁴ Janse van Rensburg (2007) *African Journal of Psychiatry* 207.

¹⁸⁵ Janse van Rensburg (2007) *African Journal of Psychiatry* 207.

patient's language of preference.¹⁸⁶ This aspect is of particular importance in South Africa's culturally diverse context.

6.3.8 Capacity, insight and judgement

In practice, decision-making capacity is often judged in terms of whether the patient displays impaired insight and/or judgement.¹⁸⁷ Insight and judgement are assessed as part of the Mental Status Examination ("MSE"), a psychiatric instrument which is sometimes regarded as analogous to the physical medical examination.¹⁸⁸ The MSE is commonly used as part of a standard psychiatric assessment or clinical interview and serves to record the clinician's overall impressions and observations of the patient.¹⁸⁹ It encompasses such aspects as appearance; speech; mood and affect; thinking and perception and sensorium.¹⁹⁰ Sensorium includes the aspects of insight and judgement.¹⁹¹

Insight

Insight relates to the ability to understand an objective reality.¹⁹² In context of decision-making capacity, insight refers to the patient's degree of self-awareness and understanding of his own mental health problems and the reasons behind his maladaptive behaviour.¹⁹³ It can be interpreted as encompassing both insight

¹⁸⁶ Zabow (2008) *South African Journal of Bioethics and Law* 62.

¹⁸⁷ Potocnik & Pienaar 275; Zabow (2008) *South African Journal of Bioethics and Law* 62, confirmed by M Swanepoel, personal communication, 8 April 2014, D Meeko, personal communication, 21 January 2015 and SA Amos, personal communication, 21 January 2015.

¹⁸⁸ Black & Andreasen 20.

¹⁸⁹ Sadock *et al Volume I* 908. The standard use of the MSE is owed to its usefulness in confirming suspicions of capacity impairment, and motivating further investigation – R Macfarlane, personal communication, 16 September 2014.

¹⁹⁰ Sadock *et al Volume I* 908-909.

¹⁹¹ Sadock *et al Volume I* 908-909.

¹⁹² Sadock *et al Volume I* 925.

¹⁹³ Sadock *et al Volume I* 909; Waldinger RJ (1986) *Fundamentals of psychiatry* 74; Potocnik & Pienaar 275; Black & Andreasen 605.

“within” (does the patient realise that he is mentally ill?), and “around” (does the patient also realise that he is in need of mental health treatment, and that he must, for instance, follow through with an appropriate treatment regimen?).¹⁹⁴

A person’s level of insight may be gauged by asking straightforward questions about why he is seeking psychiatric advice, whether he believes anything is the matter with him, why he believes he is being interviewed and whether he believes he can benefit from or needs mental health treatment.¹⁹⁵ If the patient realises that he is mentally ill, he might have limited insight, but if not, he would lack insight altogether.¹⁹⁶

Persons tend to display a lack of insight during mania;¹⁹⁷ dementia;¹⁹⁸ schizophrenia,¹⁹⁹ and personality disorders.²⁰⁰ Psychosis or mania, or other severe disorders including brain damage or brain dysfunction; mood disorders and anxiety; substance use disorders and eating disorders are associated with impaired insight as well as impaired judgment.²⁰¹

Judgement

Judgement relates to a person’s ability to assess a situation correctly and to act in a manner appropriate to this assessment.²⁰² It relates to a person’s ability to act upon his insight and awareness, and his ability for appropriate decision-making in

¹⁹⁴ Black & Andreasen 24; M Swanepoel, personal communication, 8 April 2014.

¹⁹⁵ Waldinger 74; Black & Andreasen 24.

¹⁹⁶ M Swanepoel, personal communication, 8 April 2014.

¹⁹⁷ Owing to euphoria – Black & Andreasen 148.

¹⁹⁸ Black & Andreasen 89.

¹⁹⁹ Black & Andreasen 116. A schizophrenic person may typically believe that there is nothing abnormal about his mental state.

²⁰⁰ Black & Andreasen 292. Persons suffering from personality disorder tend to blame other people for the problems caused by their own maladaptive traits.

²⁰¹ R Macfarlane, personal communication, 16 September 2014.

²⁰² Sadock *et al* *Volume I* 925.

everyday life.²⁰³ Judgement further refers to someone's understanding of the likely outcome of his behaviour, and his ability to weigh up different options and to plan and behave appropriately in social situations within his particular culture and value system.²⁰⁴ Cultural considerations are of particular interest in culturally diverse contexts such as South Africa.²⁰⁵

Judgement may be assessed by taking the person's recent life choices into consideration, or by asking a formal hypothetical question, such as how he would react to finding a stamped, addressed envelope on the ground or what he would do if he smelled smoke inside a theatre.²⁰⁶

Impaired judgement is usually found among individuals who have been poorly socialised or who experience problems with impulse control.²⁰⁷ The same applies to persons with substance-related problems,²⁰⁸ brain damage, psychotic illness, mood disorders (manic episodes,²⁰⁹ as well as depressive disorders), and anxiety.²¹⁰

6.3.9 Abilities models of assessing mental capacity

Aside from the insight and judgement criteria, so-called "abilities models" have been devised for assessing patients' functional psychological abilities relating to decision-

²⁰³ Potocnik & Pienaar 275-276; Black & Andreasen 24; M Swanepoel, personal communication, 8 April 2014.

²⁰⁴ Waldinger 74; Sadock *et al Volume I* 909; Black & Andreasen 606.

²⁰⁵ Zabow (2008) *South African Journal of Bioethics and Law* 62.

²⁰⁶ Waldinger 74; Sadock *et al Volume I* 909; Black & Andreasen 24.

²⁰⁷ Waldinger 74.

²⁰⁸ This appears to be true of stimulant abuse in particular – Black and Andreasen 273.

²⁰⁹ Many people display poor judgement by doing foolish, reckless and dangerous things during mania – Black & Andreasen 49.

²¹⁰ Waldinger 74.

making capacity. These tests employ the abilities of a mentally competent person as an “operational test” for assessing capacity.²¹¹

Grisso & Appelbaum

One example is the “four abilities model” by Grisso and Appelbaum, which considers a person mentally incapable of consenting to treatment if they are unable to:

- indicate a choice;
- understand information related to their decision about treatment;
- appreciate the implication of the information with regard to their own circumstances; and
- use this information to reason logically.²¹²

Van Staden & Krüger

South African authors Van Staden and Krüger have devised a similar test, which suggests that mental incapacity for purposes of the MCHA should mean the inability to:

- understand what is being consented to;

²¹¹ Beauchamp & Childress 71-72.

²¹² Grisso T & Appelbaum PS (1998) *Assessing competence to consent to treatment: a guide for physicians and other health professionals* & Grisso T & Appelbaum PS ‘Comparison of standards for assessing patients’ capacities to make treatment decisions’ (1995) *American Journal of Psychiatry* 152 at 1033-1037, as cited in Beauchamp & Childress 107.



- reach a conclusive decision or choice;
- communicate the consent; or
- accept that the proposed intervention or treatment is necessary.²¹³

The test illustrates that mental illness may adversely affect mental capacity in a variety of different ways. Conditions such as dementia, severe learning disability or psychotic illness can destroy the patient's understanding of what they are consenting to and may also prevent them from communicating their consent.²¹⁴ Dementia, severe learning disability and mania (due to indifference, ambivalence or indecisiveness) may prevent rational choice.²¹⁵ Various mental illnesses may further prevent the patient from accepting the need for a particular intervention.²¹⁶

The fourth aspect, inability to accept the need for treatment, is probably the most problematic, particularly in psychotic illness such as schizophrenia, where the patient would typically insist that they are not ill.²¹⁷ For example, a mentally ill person who gives "consent" to mental health treatment but does not accept that the treatment is necessary, according to this test does not give valid informed consent because they

²¹³ Van Staden & Krüger (2003) *Journal of Medical Ethics* 41. The first three criteria resonate in the legal validity requirements for consent as discussed in chapter 3 of this dissertation, in terms of knowledge, appreciation, understanding and actual subjective consent. The fourth aspect, acceptance of the need for treatment, reflects the clinical "insight" aspect of capacity, particularly the second aspect of insight as discussed in the preceding paragraphs.

²¹⁴ Van Staden CW & Krüger C 'Incapacity to give informed consent owing to mental disorder' (2003) 29 *Journal of Medical Ethics* 41 at 41.

²¹⁵ Van Staden & Krüger (2003) *Journal of Medical Ethics* 41.

²¹⁶ Van Staden & Krüger (2003) *Journal of Medical Ethics* 41.

²¹⁷ Van Staden & Krüger (2003) *Journal of Medical Ethics* 42. This demonstrates a lack of insight on the part of the patient, which also resonates in the "insight and judgement test" of mental capacity.

lack the mental capacity to do so.²¹⁸ Such a person's actions are not autonomous because the conduct is being informed by the mental disorder.²¹⁹

The patient might not realise the full extent of his illness.²²⁰ For example, a patient with severe major depressive disorder who also suffers from Cotard's delusion that he is dead, would most likely be able to understand that he is consenting to treatment for his depression, to exercise a rational choice about the treatment and to communicate his consent.²²¹ Convinced that he is already dead, however, he would be unable to accept the need for treatment of the depressive disorder and is therefore unable to give valid informed consent.²²²

This model for assessing mental capacity can also be applied to assess the ability to consent to treatment for medical conditions. A user might agree to the amputation of a gangrenous limb, but due to mental disorder be unable to communicate their consent, or unable to understand the nature, purpose and consequences of the procedure, or exercise a decisive choice or accept the need for the amputation, in which case his assent would never amount to valid consent.²²³

The same would apply to a patient suffering from schizophrenia, who refuses emergency surgery for a ruptured peptic ulcer based on the belief that the surgery would allow magical healing spirits to escape from his stomach, as a result of which

²¹⁸ Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²¹⁹ Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²²⁰ Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²²¹ Example taken from Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²²² Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²²³ Van Staden & Krüger (2003) *Journal of Medical Ethics* 41-42.

he would die.²²⁴ His refusal of the surgery would not be valid because the mental illness prevents acceptance of the need for surgery.²²⁵

6.4 Risk of harm to self or others

The MHCA requires practitioners to assist in assessing the risk that a user might cause their own death or irreversible harm to their health; might inflict serious harm upon him- or herself or someone else or cause serious damage to or loss of property;²²⁶ endanger their own or others' health or safety;²²⁷ or seriously harm him- or herself or someone else, or damage their financial interests or reputation.²²⁸ The Act, however, fails to specify what an acceptable level of risk is or how exactly each of the risk-items should be evaluated, which leaves the evaluating practitioner with a wide discretion. Being the more relevant and probably the less easy to evaluate, suicide risk and dangerousness are subsequently further discussed.

The assessment of suicide risk and dangerousness both carry social-, legal- and even potential liability implications for the assessing practitioner.²²⁹ The law should acknowledge that, like accurate diagnosis, the accurate prediction of prognostic

²²⁴ Example from Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²²⁵ Van Staden & Krüger (2003) *Journal of Medical Ethics* 42.

²²⁶ S9(1)(c) of the MHCA.

²²⁷ S26(b)(i) of the MHCA.

²²⁸ S32(b) of the MHCA.

²²⁹ Regarding the issue of suicide risk, see Waldinger 325; World Health Organization (2014) *Preventing suicide: a global imperative* available at http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/ (accessed 30 October 2014). The bereaved family (or "suicide survivors") who suffer emotional shock could claim common-law damages from the practitioner in the event of a preventable suicide. See *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A); *Barnard v Santam Bpk* 1999 (1) SA 202 (SCA) and *Road Accident Fund v Sauls* 2002 (2) SA 55 (SCA) regarding delictual liability for emotional shock and psychiatric injury. See also Carstens & Pearmain 750-751. Regarding dangerousness, see Waldinger 357; *Tarasoff v Regents of University of California* 83 ALR 3rd 1166 (Cal 1976) and *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) concerning the duty toward third parties where a dangerous person is involved. See also South African judgements *McMorrow v Colonial Government* 1906 CPD 626 and *Seema v Executive Member of Gauteng* 2002 (1) SA 771 (T), both discussed in Carstens & Pearmain 749-751, regarding liability for failure to control a dangerous situation involving a psychiatric patient.

aspects such as suicide risk or risk of other violent behaviour is at best challenging, not only due to the unpredictability of human behaviour, but also due to time- and resource constraints.²³⁰ Clinical risk assessment cannot be done with absolute certainty.²³¹ Perfect predictions should not be expected of the practitioner, but rather predictions done with the reasonable degree of skill, knowledge and care expected of the average mental health care practitioner in the same field.²³²

6.4.1 Suicide risk

Standard clinical assessment of risk is likely to involve a clinical interview, which might include an MSE and collateral information.²³³ Further testing can be done based on the interview findings.²³⁴ A clinical interview tailored to assessing suicide risk could include an assessment of the user's history and circumstances, available emotional resources and social support.²³⁵ An MSE might focus specifically on depression, psychosis and homicidal ideation.²³⁶

²³⁰ *Tarasoff* at 1189; Waldinger 326, 341-342; Janse van Rensburg (2007) *African Journal of Psychiatry* 208; Kaliski S 'The "dangerous offender" and risk assessment' in *Psycholegal assessment in South Africa* (ed Kaliski S) (2007) 113 at 116; Moosa & Jeenah (2008) *African Journal of Psychiatry* 110; Krüger C & Rosema D 'Risk factors for violence among long-term psychiatric in-patients: a comparison between violent and non-violent patients' (2010) 13 *African Journal of Psychiatry* 366 at 366.

²³¹ At best, a percentage of risk might be calculated – Moosa & Jeenah (2008) *African Journal of Psychiatry* 110.

²³² The test for negligence in the context of the failure to warn against a potentially dangerous psychiatric patient appears in *Tarasoff* at 1177. It is similar to the test of medical negligence in South Africa in general (*Mitchell v Dixon* 1914 AD 519 at 525; *Van Wyk v Lewis* 1924 AD 438 at 444), and having regard to S39(1) of the CRSA, it is likely that South African courts would follow the judgement in *Tarasoff* if confronted with a similar set of facts. Also Nöthling Slabbert, M (2014) 'South Africa' in Nys H (ed) (2014) *International Encyclopaedia of Laws: Medical Law* 1 at 95-96.

²³³ R Macfarlane, personal communication, 16 September 2014.

²³⁴ R Macfarlane, personal communication, 16 September 2014.

²³⁵ Simon RI 'Suicide risk: Assessing the unpredictable' *The American Psychiatric Publishing Textbook of suicide assessment and management* (eds Simon RI & Hales RE) (2006) 125; Waldinger 333.

²³⁶ Waldinger 333.

While good clinical judgement remains imperative,²³⁷ taking cognizance of risk- and protective factors may assist in the overall assessment. Relevant factors may include the user's age; sex; marital status; employment- and social status; psychiatric disorder (particularly mood disorders, mood disorders,²³⁸ schizophrenia, substance-related disorders, personality disorders,²³⁹ and anxiety disorders,²⁴⁰ and comorbidity (dual diagnosis)); specific psychiatric symptoms (including hopelessness, anxiety, agitation or intense suicidal ideation);²⁴¹ psychiatric history (especially a history of suicide risk, self-harm or substance-related problems in the individual or their immediate family)²⁴² and medical illness (particularly where associated with disfigurement, loss of independence or mobility, or chronic and unmanageable pain).²⁴³ Recent life stresses, including any losses or interpersonal conflicts may also contribute to a higher risk of suicide.²⁴⁴

Religion and culture may contribute to a lower suicide risk for patients with strong religious beliefs and those whose religions condemn suicide as wrong or sinful.²⁴⁵ Likewise strong social support; life satisfaction; reality testing ability and problem-solving skills appear to lower suicide risk.²⁴⁶

²³⁷ Simon 23; Jacobs DG, Baldessarini RJ, Conwell Y, Fawcett JA, Horton L, Meltzer H, Pfeffer CR & Simon RI 'Appendix: APA Practice guideline for the assessment and treatment of patients with suicidal behaviours: Executive summary of recommendations' in *The American Psychiatric Publishing Textbook of suicide assessment and management* (eds Simon RI & Hales RE) (2006) 577 at 579.

²³⁸ DSM-5 has lowered the criteria and done away with the former "grief exclusion". Adverse life events, losses and other stressors including the death of a loved one are in any event considered independent risk factors for suicide. Sadock & Sadock 910.

²³⁹ Simon 17; Sadock & Sadock 898-900.

²⁴⁰ Sadock & Sadock 900.

²⁴¹ Waldinger 328; Jacobs *et al* 587-589.

²⁴² Waldinger 328; Simon 21; Sadock & Sadock 897.

²⁴³ Waldinger 327-328; Jacobs *et al* 588; Simon 16-17; Horton 125-126; Sadock & Sadock 897-898, 910.

²⁴⁴ Waldinger 328-329.

²⁴⁵ Sadock & Sadock 898.

²⁴⁶ Jacobs *et al* 589; Simon 23-24.

6.4.2 Dangerousness and homicide risk

Assessment of dangerousness may be done clinically,²⁴⁷ or by means of structured, actuarial risk assessment tools,²⁴⁸ or a combination of these methods.²⁴⁹

If assessment is done in the context of a clinical interview, this would likely include an assessment of the user's history and an MSE, focusing on delusions, hallucinations, depersonalization, paranoia, suicidal ideation and impulsivity.²⁵⁰ Personal characteristics associated with violence may be considered and can be useful in putting threats of violence into perspective.²⁵¹ Previous violent behaviour is usually the best indicator of future risk.²⁵² In practice, many involuntarily admitted patients have a recent history of violent behaviour which makes his or her dangerousness to society blatantly obvious, often associated with psychosis or substance-induced psychosis.²⁵³

²⁴⁷ Kaliski 118; Roffey & Kaliski (2012) *African Journal of Psychiatry* 229. Clinical methods are more informal and intuitive, and allow better assessment of the specific individual. They are inevitably more difficult to teach and study as they are opinion-based.

²⁴⁸ These methods are similar to the data-collection and mathematical calculations used by insurance companies and weathermen – Pagani & Pinard 16; Roffey & Kaliski (2012) *African Journal of Psychiatry* 227. People are not weather patterns, though, and a major drawback of this method is that it is more valid for a population on average than for a specific individual – Roffey & Kaliski (2012) *African Journal of Psychiatry* 229; Krüger & Rosema (2010) *African Journal of Psychiatry* 367. Actuarial methods which may be employed include: the Violent Risk Appraisal Guide (VRAG); Historical-Clinical-Risk-Management-20 ("HCR-20"); the MacArthur Risk Assessment Study and the Psychopathy Checklist – Revised ("PCL-R") - Kaliski 117-118; Roffey & Kaliski (2012) *African Journal of Psychiatry* 229, 231.

²⁴⁹ Kaliski 118; Roffey & Kaliski (2012) *African Journal of Psychiatry* 229 & 231; Pagani L & Pinard G 'Clinical assessment of dangerousness: An overview of the literature' in *Clinical assessment of dangerousness: empirical contributions* (eds Pinard G & Pagani L) (2009) 1 at 14-17. It has been suggested that the combination of both methods yields superior results.

²⁵⁰ Waldinger 356; Pagani & Pinard 14.

²⁵¹ Waldinger 348; Roffey & Kaliski (2012) *African Journal of Psychiatry* 229.

²⁵² Waldinger 348; Sadock & Sadock 911; Krüger & Rosema (2010) *African Journal of Psychiatry* 367.

²⁵³ Meeko D, personal communication, 21 January 2015 – in an extreme case, the patient might have recently pulled out somebody's eye or tongue during a psychotic episode, in which case his behaviour should be evidence enough of a risk of harm.

Other factors which may offer useful indications of risk include age; sex; substance-related problems; employment- and social status; self-destructive behaviour and the presence of mental disorder.²⁵⁴ The aspect of mental disorder and risk of violence is controversial,²⁵⁵ but some mental illnesses may lead to impaired impulse control or judgement, thus contributing to risk of violence.²⁵⁶ This is especially true of psychotic disorders; mood disorders; personality disorders, substance related disorders and certain organic conditions such as temporal lobe epilepsy, brain damage, dementia and delirium.²⁵⁷

Risk factors reported to be particular to homicidal behaviour include violent and unstable family life; poor housing; few social relationships; isolation; poor functioning; lower socio-economic status; unemployment and lower levels of education; a history of alcohol- and substance abuse; anxiety; depression; poor self-esteem; high hostility and impulsiveness; deficient coping strategies; loss of touch with reality; previous arrests or homicides; clear plans or thoughts of homicide and availability of a weapon.²⁵⁸

Based on the outcome of the assessment, the clinician can recommend an appropriate treatment plan for the user – in this regard it is often “better to be safe than sorry”.²⁵⁹ If it appears that a user is dangerous, the Mental Health Review

²⁵⁴ Waldinger 348-349; Sadock & Sadock 911.

²⁵⁵ Waldinger 341-342. Violence or dangerousness is not a diagnosis in itself, but rather a behaviour which can occur across a variety of diagnostic categories – and among people without a history of mental illness.

²⁵⁶ Waldinger 350-351.

²⁵⁷ Waldinger 351-354; Monahan J ‘Major mental disorder and violence: Epidemiology and risk assessment’ in *Clinical assessment of dangerousness: empirical contributions* (eds Pinard G & Pagani L) (2009) 89 at 90-91; Tardiff K ‘Axis I disorders and dangerousness’ in *Clinical assessment of dangerousness: empirical contributions* (eds Pinard G & Pagani L) (2009) 103 at 103-104.

²⁵⁸ Sadock & Sadock 151.

²⁵⁹ Waldinger 357.

Board would refer him to an institution equipped with the necessary seclusion- and restraint facilities.²⁶⁰

6.5 Conclusion

This chapter sought to clarify some of the areas of overlap between psychiatry and the law, particularly where informed consent in the context of the MHCA is concerned.

Mental illness was firstly considered. In this regard it was shown that various definitions for the entity exist in both psychiatry and the law, but that the MHCA requires a system of diagnosis which is legally valid, useful and reliable and on par with international standards. It was demonstrated that the DSM-5 probably lacks the level of credibility and validity required and that as such, the ICD might be more suitable for use as a diagnostic system on its own for purposes of the MHCA. It was shown that the absence of a definition of mental capacity in the MCHA could be problematic in view of the fact that capacity can be such a challenging ability to evaluate. Approaches to- and characteristics of capacity were described, and assessment methods for mental competence were more closely analysed. It was shown that although no legal guidelines or prescriptions for assessing risk of harm to self or others exist, and there are no fail-proof clinical assessment methods either, perfect predictions should not be expected and the practitioner should conduct his assessment as would the reasonable practitioner in the same field of expertise.

²⁶⁰ D Meeko, personal communication, 21 January 2015.

Chapter 7

Recommendations

7.1 Introduction

The preceding chapters have identified deficiencies in legislation governing informed consent by mentally ill persons. The purpose of this chapter is to make practical suggestions which should serve the purpose of clarifying the meaning of certain key concepts within the Mental Health Care Act (the “MHCA”),¹ thereby reducing confusion and misunderstanding between lawyers, psychiatrists and the public, and ensuring the better protection of mentally ill persons’ fundamental human- and health rights through more consistent and sensible decision-making and procedures.

This chapter will make suggestions for further possible amendments to the MHCA, which pertain specifically to the existing definition of “mental illness”, the addition of a definition for “consent” and the addition of a definition for decision-making “capacity” which would at the same time serve as a set of criteria for the assessment of capacity for purposes of the Act.

In addition, it will be suggested that informed consent forms for mental health treatment should be utilised, at least insofar as the more invasive forms of mental health care, treatment and rehabilitation services are concerned.² In this regard, a draft consent form will be presented together with comments.

¹ 17 of 2002, as amended (the “MHCA”).

² Hereafter referred to as “mental health treatment”.

As illustrated in the preceding chapters, the MHCA, for all its laudable advancements in the area of human rights protection of the mentally ill, is lacking in terms of guidelines and definitions for certain key concepts crucial to the implementation of its aims. It does, however, lack clarity regarding the concepts of mental illness, consent and mental capacity. The following proposed definitions aim to create better clarity around problematic concepts, whilst ensuring compliance with constitutional-, legislative-, common law- and ethical standards.

7.2 Proposed regulations regarding the assessment and diagnosis of mental illness

The definition of “mental illness” contained in section 1(xxi) of the MHCA makes reference to a diagnosis of mental illness made in terms of accepted diagnostic criteria. The MHCA further determines that the minister of health may make regulations to prescribe guidelines and methodologies to be used in conducting a psycholegal assessment and making the diagnosis of mental illness.³

The minister has to date made no such regulations, and it is submitted that doing so might serve to lessen confusion surrounding the aspect and to promote more consistent diagnosis and decision-making.

It has been submitted that the “accepted diagnostic criteria” in terms of section 1(xxi) of the MHCA should be interpreted to include both the ICD- and DSM systems of classification and diagnosis.⁴ Given the widespread controversy over the recently-released DSM-5, however, it is submitted that the minister’s regulations should prescribe the ICD-system alone as the accepted system for the diagnosis of mental illness. As discussed in the preceding chapters, the use of the ICD-system is

³ S66(1)(a) & (b) & S67(2) of the MHCA; Landman AA & Landman WJ (2014) *A practitioner’s guide to the Mental Health Care Act 5*.

⁴ Landman & Landman 5; also Chapter 6 of this study.

already compulsory in the general public- and private health care sectors in South Africa. Should the controversy surrounding DSM-5 lessen and the manual, or perhaps even a later edition thereof, become more accepted in the psychiatric field, the regulations could be amended so as to include both the ICD- and the DSM systems.

7.3 Proposed definition of “consent”

The MHCA lacks a definition of consent. It is submitted that a definition may be included in the Act, either at section 1 or as part of Chapter V thereof. Consent must comply with the common law requirements for valid informed consent as stipulated in chapter 3 hereof, as well as requirements of sections 6-8 of the National Health Act. As illustrated in the preceding chapters, international law- and ethical standards cite information, voluntariness and capacity as major requirements of valid informed consent.

A well-drafted example of a legal definition for “consent” (informed consent) in context of medical law may be found in section 4 of the Sterilisation Act 44 of 1998. The Sterilisation Act defines “consent” to a sterilisation procedure as consent given freely and voluntarily without any inducement, and given by a person who:

- Has been given a clear explanation and adequate description of:
 - the proposed plan of the sterilisation procedure, and
 - the consequences, risks and the reversible or irreversible nature thereof.
- Has been given advice that the consent may be withdrawn any time before the treatment.
- Has understood and signed the prescribed consent form.

This definition is specific to sterilisation procedures, however, if it is to be used as a guideline for informed consent to mental health treatment, it will need to be adjusted somewhat to suit that context. It is nevertheless suggested that a somewhat similar definition would be well-suited for inclusion in the MHCA, in relation to consent to mental health treatment. The following definition of consent (informed consent) is proposed for inclusion in section 1 of the MHCA:

“consent”

For purposes of this Act, consent by a mental health care user should be interpreted as informed consent.⁵ Before giving consent to mental health care, treatment and rehabilitation, the user must:⁶

- a) be adequately informed as to the nature and extent of:
 - (i) the proposed or medical treatment or mental health care, treatment and rehabilitation services; and*
 - (ii) the typical and material risks involved therein; and**
- b) give their consent freely and without undue influence; and*
- c) be informed of their right to revoke their informed consent given advice that the consent may be withdrawn any time before the treatment; and*

⁵ This provision refers the reader back to the common law requirements and position regarding consent, which should naturally apply together with the specific elements that are listed in the proposed definition.

⁶ The term “user” is included in the proposed definition. “User” is defined at S1(xix) of the MHCA as a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include-

- (i) prospective user;
- (ii) the person’s next of kin;
- (iii) a person authorised by any other law or court order to act on that persons behalf;
- (iv) an administrator appointed in terms of this Act; and
- (v) an executor of that deceased person’s estate and “user” has a corresponding meaning.

- d) *not have been found to lack the capacity to make informed decisions relating to mental health- or medical treatment or the need for such treatment, as defined in this Act;*⁷ and
- e) *in the event of electroconvulsive therapy or psychosurgery, the user must have understood and signed the prescribed consent form.*⁸

7.4 Proposed definition and criteria for “capacity”

7.4.1 Why the need for a legal definition for capacity?

It is submitted that a definition with criteria for mental capacity to make mental treatment-related decisions be included in the MHCA. While lawyers are (at least for the most part!) not psychiatrists, and it is imprudent for them to overstep into the clinical domain, practical considerations dictate that certain juristic tests should be formulated for use in limited circumstances.⁹ Given the complexity of the psychiatric field it would of course, be unrealistic to suggest that a juristic test can be formulated in order to objectively measure a person’s factual mental capacity at a given point in time.¹⁰

The purpose of such a definition would not be for the law to intrude/overstep into psychiatrists’ domain and area of expertise (indeed the judiciary is cautioned against the imprudence and even dangerousness of doing precisely this in *S v Mahlinza*).¹¹ Rather, the aim is to clarify and delineate, even if it is by means of an inevitably over-simplified juristic test, what capacity in the legal sense should mean for purposes of the Act. The purpose of such a provision is merely to “point assessing practitioners in the same direction” so that they do their assessment of a legal

⁷ This section would make reference to the new proposed definition of “capacity” to make informed decisions, as discussed later on in this chapter.

⁸ It is proposed later in this chapter that written consent should be obtained to the more invasive forms of mental health treatment, such as electroconvulsive therapy (ECT).

⁹ Strauss SA & Strydom MJ (1967) *Die Suid-Afrikaanse geneeskundige reg* 202.

¹⁰ Strauss & Strydom 202.

¹¹ 1967 1 SA 408 (A) at 417F-H.

concept from the same “set of legal notes” in order to ensure better consistency. The expert method of assessment of the legal criteria is of course left to the expertise of the practitioner. It will also hopefully bring the psychiatrists and the legal practitioners who rely on their expert assessments to a better understanding in this regard.

It is submitted that this reveals a need for a “common ground” test, even if it is limited to a legal test for purposes of the Act.¹² The test should be specific to the context of mental health decision-making capacity, though, meaning that it cannot be the same as the test for criminal capacity – decision-making about mental health treatment has little if anything to do with committing crime, after all.

7.4.2 Why the test for criminal mental capacity works

An example of a well-established juristic test for capacity, the elements of which are evaluated at the hand of expert psychiatric testimony, may be found in section 78(1) of the Criminal Procedure Act.¹³ Section 78(1) reads as follows:

A person who commits an act which constitutes an offence and who at the time of such commission suffers from a mental illness or mental defect which makes him incapable-

- (a) of appreciating the wrongfulness of his act; or
- (b) of acting in accordance with an appreciation of the wrongfulness of his act,

shall not be criminally responsible for such act.

¹² Like any other specialised legal test for capacity, the test for decision-making capacity would have limited application – it would not make sense to use the same test for mental capacity to commit a crime, in context of the mental capacity to consent to mental health treatment – Strauss & Strydom 202.

¹³ The test is based on the English case of *R v M’Naghten* (1843) 8 ER 718, which consisted initially of the “right” or “wrong” test, or the ability to distinguish right from wrong. On recommendation of the Rumpff Commission of Inquiry of 1967 the criteria were modified so as to include both the cognitive (thinking, reasoning, learning, planning)- and conative (exercise of will/volition) elements of criminal capacity. If either of the two is impaired, criminal capacity and liability will be lacking – Burchell J (2013) *Principles of criminal law* 4th Ed 247, 250, 272, 275.

This identifies three elements to the test of criminal capacity: firstly, the presence of mental illness, secondly, at time of the offence, and thirdly, which affected the accused's criminal capacity in terms of their insight (cognitive abilities) or self-control (conative abilities).¹⁴

The test in section 78(1) is used for only criminal capacity for legal purposes. It does not comprise a checklist or a substitute for expert assessment, nor does it substitute expert psychiatric testimony, which still has a crucial part to play in the court's final determination of the accused's mental abilities.¹⁵

It is submitted that the analogy between section 78(1) of the Criminal Procedure Act and the MHCA is suitable, owing to the underlying similarities as well as the degree of overlap between the two areas of the law. Incapacity in the sense of section 78(1) of the Criminal Procedure Act may, for instance, lead to a referral via court order for mental health treatment as an involuntary user, as explained in chapter 5 of this study. The test for criminal capacity has furthermore been applied in the context of civil law (the law of delict) at least once before in a reported judgement.¹⁶

7.4.3 A suggested definition and test of capacity

It is proposed therefore, that the test for consent-giving capacity of authors Van Staden and Krüger be incorporated into the MHCA.¹⁷ For the sake of simplicity the definition could be included in section 1 of the MHCA, together with the rest of the Act's definitions. Alternatively it might be included in chapter V of the Act, where its criteria are the most relevant. The definition, which would by implication serve as evaluation criteria for decision-making capacity, could read as follows:

¹⁴ Burchell 247.

¹⁵ Burchell 276.

¹⁶ *Weber v SANTAM Versekeringsmaatskappy Bpk* 1983 (1) SA 381 (A) at 382.

¹⁷ Van Staden CW & Krüger C 'Incapacity to give informed consent owing to mental disorder' (2003) 29 *Journal of Medical Ethics* 41 at 41.

“capacity”

A mental health care user who-

- a) understands what he or she is consenting to;*
- b) can reach a conclusive decision or choice;*
- c) is able to communicate his or her consent; and*
- d) can accept the need for the proposed intervention or mental health care, treatment or rehabilitation services,¹⁸*

will be deemed to have the necessary capacity to make decisions about the need for medical treatment or mental health care, treatment or rehabilitation services for purposes of this Act.

7.5 Informed consent forms and disclosure documents

7.5.1 Psychiatric consent forms and disclosure documents

It is suggested that written consent be obtained to mental health treatment, or at least to the more invasive forms thereof, such as electroconvulsive therapy (“ECT”). Consent documentation can include a patient information sheet with information about the particular mental health treatment.

Specific consent forms could be tailored to the specific forms of mental health treatment, and the forms could be included as Annexures to the Mental Health Care

¹⁸ Van Staden & Krüger (2003) *Journal of Medical Ethics* 41.

Act, alternatively it could be the responsibility of mental health institutions and practitioners to have the necessary forms at hand and to obtain the necessary consent.

The informed consent form may be accompanied by a disclosure document, which contains information about the specific mental health treatment and which may serve to supplement a proper disclosure conversation with the user.¹⁹ It is suggested that blank spaces be left in the document where the practitioner can complete some of the specific risks inherent in the treatment, so as to better cater to the individual user's needs.²⁰

An example of a draft informed consent form follows.

¹⁹ Van Oosten 'Disclosure documents and informed consent: the pros and cons' (1993) *Medicine and Law* 651 at 656.

²⁰ Van Oosten (1993) *Medicine and Law* 652.

7.5.2 Draft informed consent form*²¹

INFORMED CONSENT TO MENTAL HEALTH CARE, TREATMENT AND REHABILITATION				
A. DETAILS OF PATIENT			B. DETAILS OF REPRESENTATIVE	
Full names:				Full names:
ID number:				ID number:
Admission status:	Voluntary	Assisted	Involuntary	Relation to patient:
	Inpatient	Outpatient		
Home language:				Address:
				Contact:
C. DETAILS OF PRACTITIONER			D. DETAILS OF ESTABLISHMENT	
Full names:				Name:
MP/Registration nr:				Physical address:
Qualification/s:				
Signature:				Contact:
E. DETAILS OF TREATMENT			F. NOTES	
Procedure/s:				
ICD code/s:				
Treatment date/s:				
G. CONFIRMATION OF CONSENT				
<p>I, _____, hereby confirm that I have discussed the abovementioned treatment/procedure with my mental health care provider, and that I freely and voluntarily consent to undergoing the said procedure to be performed by my mental health care provider.</p> <p>I further confirm that I have been informed by my mental health care provider of: my mental health status; the range of diagnostic procedures and treatment options generally available to me; the benefits, risks, costs and consequences generally associated with each of these options; of my right to refuse mental health services and of the implications, risks and obligations involved if I should decide to do so.</p> <p>I have been provided with a copy of the relevant patient information sheet and of this consent form, and have been given enough time to consider the information before I made the decision regarding this mental health treatment. I have been given the opportunity to ask further questions about the treatment. My right to revoke consent has been explained to me.</p> <p>Signed at _____ on this _____ day of _____ 20 ____.</p>				
_____	_____	_____	_____	_____
Representative	Patient	Witness 1	Witness 2	

²¹ See the draft consent forms and ECT patient information sheet in Segal J & Thom R 'Consent procedures and electroconvulsive therapy in South Africa: impact of the Mental Health Care Act' (2006) 9 *South African Psychiatry Review* 206 at 211-215 for a similar example.

7.6 Conclusion

This chapter has sought to propose solutions to some of the most obvious technical difficulties and deficiencies in the MHCA's provisions governing informed consent by mentally ill persons. It was demonstrated that a few simple clarifications, by means of amendments to the MHCA, could serve to reduce much of the present uncertainty and inconsistency in the mental health care system.

First, suggestions were made regarding the existing definition of "mental illness" in section 1 of the MHCA and to the powers of the minister of health to make regulations regarding standards and methods for psychiatric diagnosis in terms of sections 66(1)(a) and (b) and section 67(2) of the MHCA. The MHCA's definition of mental illness lends itself to uncertainty, seeing as the DSM-5 has given rise to much controversy in terms of exactly which psychiatric nosological systems should be considered acceptable. It was accordingly suggested that the minister should make regulations prescribing that only the ICD system, and not the DSM, should be used for purposes of diagnosing psychiatric disorders.

Secondly, it was recommended that a definition for "consent" (informed consent) be incorporated into the MCHA. Although it should be obvious to legal practitioners that "consent" in the context of the MHCA should, in terms of common law, imply informed consent, this fact and its implications might not be readily apparent, particularly to mental health care practitioners who are not also legal practitioners. A definition similar to that found in the Sterilisation Act 44 of 1998 was proposed for incorporation into the MHCA.

The fact that the MHCA lacks a definition of mental "capacity" is problematic as it leaves the assessment of capacity as a legal concept in the hands of mental health practitioners, who might tend to view capacity in clinical terms and who might have

differing views as to what capacity to consent to mental health treatment should comprise. A definition, consisting of four assessment criteria, was proposed for decision-making “capacity”, and it was strongly recommended that this be included in the MHCA in a way similar to the criteria contained in section 79(1) of the Criminal Procedure Act. The definition would double as a “legal test” for consent-giving capacity in the context of the MHCA. It would serve to provide clarity and guidance as to the meaning and assessment of capacity for purposes of the Act. The criteria were based on the four-abilities model of capacity of Van Staden and Krüger, which was chosen to reflect clinical views while at the same time containing elements of legal capacity in the common law sense, and also remaining simple enough for inclusion in the Act.

Finally, it was suggested that informed consent forms be utilised more often in obtaining consent to mental health care, treatment and rehabilitation, or at least to the more invasive forms thereof, such as ECT. A draft consent form, which complies with the provisions of the National Health Act as well as the MHCA was proposed for this purpose. It was suggested that such a form should be used in conjunction with a written patient information sheet as well as verbal disclosure in order to make sure that the consent obtained is properly informed.

Chapter 8

Summary and conclusion

8.1 Introduction

Throughout the preceding seven chapters, an effort was made to explore informed consent by mentally ill persons in the context of the Mental Health Care Act (the “MHCA”),¹ with specific reference to clinical aspects relevant to the MHCA. The aim was to continually integrate the discussion of informed consent by psychiatric patients into the overall legal- and ethical framework governing informed consent, including the constitution (the “CRSA”),² international guidelines, common law, health care legislation and ethical- and professional guidelines.

Difficulties and discrepancies within this legal framework, and particularly within the MHCA, were highlighted throughout the study. Toward the end of the discussion, a number of practical suggestions were made which were aimed at addressing the some of the issues that had been identified. This chapter will provide a brief overview of each of the seven foregoing chapters, and will conclude with a few final remarks.

¹ 17 of 2002, as amended (the “MHCA”).

² The Constitution of the Republic of South Africa, 1996 (the “CRSA”).

8.2 Summary of chapters

8.2.1 Chapter 1

Chapter 1 served as an introduction to the study, explaining the aims, significance, methodology and structure of the remainder of the chapters which would follow. For ease of reference, the chapter included a number of definitions and explanations of concepts which were referred to later on in the study.

8.2.2 Chapter 2

Chapter 2 provided a background of fundamental rights and principles which underlie and support informed consent. Reference was made to international human rights law; specific rights of mental health care users in terms of the MCHA as underpinned by the CRSA; infringements upon the rights of users in the legal sense, and the “balancing act” involved in justifying an infringement upon the rights of a user in the ethical sense.

8.2.3 Chapter 3

Chapter 3 sought to establish a basic legal framework for informed consent, relativizing the general principles to the context of psychiatry. The chapter referred to common law consent (*volenti non fit iniuria*); the meaning, form and characteristics of the defence of consent; validity requirements; information and standards and tests of disclosure.

8.2.4 Chapter 4

Chapter 4 briefly discussed alternative justifications for the provision of mental health treatment, where informed consent cannot be obtained. The discussion included defences against liability in the absence of informed consent, making reference to multiple defences, wrongfulness, specific grounds of justification and liability issues, with specific reference to the psychiatric context. Liability in the absence of informed consent, including the correct ground of liability – assault or medical negligence – was also discussed.

8.2.5 Chapter 5

Chapter 5 focused largely on the provisions of the MHCA governing informed consent. Section 9, establishing the right to consent to mental health treatment was discussed, followed by a more detailed exposition of chapter V of the MCHA, including voluntary-; assisted- and involuntary mental health care users. Unintended practical consequences of the MHCA, as well as the concurrent applicability of the National Health Act 61 of 2003 were referred to.

8.2.6 Chapter 6

Chapter 6 addressed the issue of discrepancies and interpretation-differences between the fields of psychiatry and the law, which may tend to result in ill-considered legal decisions. Reference was made to the clinical assessment and diagnosis of mental illness, capacity and risk as meant in chapter V of the MHCA. It was shown that the lack of clear legal definitions and guidelines in the MHCA could lead to inconsistency and confusion.

8.2.7 Chapter 7

Recommendations were made in order to address some of the issues revealed in the previous chapters. It was suggested that the Minister of Health should make regulations to the MHCA which prescribes the exclusive use of the ICD in making psychiatric diagnoses, at least until such time as the controversy surrounding the DSM-5 has been resolved. The inclusion of a definition for consent was suggested, as well as a definition for capacity, which would simultaneously serve as a legal test for capacity to consent to mental health treatment (or medical treatment) by mentally ill persons for purposes of the MHCA. Suggestions were made for informed consent documentation for certain forms of mental health treatment, including a draft informed consent form.

8.3 Concluding remarks

This study has concluded that the MHCA has made significant contributions towards changing the mental health care landscape in South Africa and better aligning it with constitutional- and international norms, values and standards. There is room for improvement, however, in terms of the MHCA's more detailed provisions dealing with informed consent related concepts such as mental illness, consent and capacity, which tend to have different meanings in law and clinical practice. Given the major part clinicians have to play in the MHCA's procedures, a lack of clear definitions and regulated standards could lead to inconsistent and ill-considered decision-making, which is in turn likely to prejudice the mental health care user. The author believes that making a few simple, practical changes to the MHCA could go a long way towards better aligning mental health care processes and improving consistency in mental health decision-making. This should further protect and promote the rights of mentally ill persons, particularly with reference to informed consent as underlined by the right to autonomy and equality, which accords with international standards as well as with the MHCA's own objectives.

Bibliography

Books

1. American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders 4th Ed Text revision* Washington, DC: American Psychiatric Association.
2. American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders 5th Ed* Washington, DC: American Psychiatric Publishing.
3. Beauchamp TL & Childress JF (2001) *Principles of biomedical ethics 5th Ed* New York: Oxford University Press.
4. Black DW & Andreasen NC (2011) *Introductory textbook of psychiatry 5th Ed* Washington, DC: American Psychiatric Publishing Inc.
5. Boberg PQR (1984) *The law of delict Volume I, Aquilian liability* Cape Town: Juta.
6. Burchell J (2013) *Principles of criminal law 4th Ed* Lansdowne: Juta.
7. Camus A *Lyrical and critical essays* (Thody PMW ed) (1968) New York: Alfred A Knopf Inc.
8. Carstens PA & Pearmain DL (2007) *Foundational principles of South African medical law* Durban: Lexis Nexis.
9. Claassen NJB & Verschoor T (1992) *Medical negligence in South Africa* Pretoria: Digma.
10. Craig WJ (ed) (1954) *The complete works of William Shakespeare* London: Oxford University Press.
11. Currie I & de Waal J (2013) *The Bill of Rights Handbook 6th Edition* Claremont: Juta.
12. Dada MA & McQuoid-Mason DJ (eds) (2001) *Introduction to medico-legal practice* Durban: Butterworths.

13. Dhai A & McQuoid-Mason D (2011) *Bioethics, human rights and health law: Principles and practice* Lansdowne: Juta.
14. Dugard J (2010) *International law: A South African perspective 3rd Ed* Cape Town: Juta.
15. Freedman AM, Kaplan HI & Sadock BJ (eds) (1975) *Comprehensive textbook of psychiatry-II 2nd Edition Volume 2* Baltimore: Williams & Wilkins.
16. Giesen D (1988) *International medical malpractice law: A comparative law study of civil liability arising from medical care* Tübingen: Mohr.
17. Glickman J (ed) (1976) *Moral philosophy: an introduction* New York: St Martin's Press.
18. Gutheil TG & Appelbaum TS (1982) *Clinical handbook of psychiatry and the law* New York: McGraw-Hill.
19. Herbert F (1980) *Direct descent* United States: Ace Books.
20. Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* Cape Town: Oxford University Press.
21. Kim SYH (2010) *Evaluation of capacity to consent to treatment and research* Oxford: Oxford University Press.
22. Kruger A (1980) *Mental health law in South Africa* Durban: Butterworths.
23. Landman AA & Landman WJ (2014) *A practitioner's guide to the Mental Health Care Act* Cape Town: Juta.
24. Mason JK, Laurie GT & Aziz M (2006) *Mason & McCall Smith's Law and medical ethics 8th Ed* New York: Oxford University Press.
25. McQuoid-Mason D & Dada M (2011) *A – Z of medical law* Cape Town: Juta.
26. Neethling J, Potgieter JM & Visser PJ (2010) *Law of delict* Durban: Lexis Nexis.
27. Nys H (ed) (2014) *International Encyclopaedia of Laws: Medical Law* Alphen aan den Rijn, NL: Kluwer Law International.
28. Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* Cambridge: Cambridge University Press.
29. Sadock BJ, Sadock VA & Ruiz P (eds) (2009) *Kaplan & Sadock's Comprehensive textbook of psychiatry 9th Ed Volume I* Philadelphia: Lippincott Williams & Wilkins.

30. Sadock BJ, Sadock VA & Ruiz P (eds) (2009) *Kaplan & Sadock's Comprehensive textbook of psychiatry 9th Ed Volume II* Philadelphia: Lippincott Williams & Wilkins.
31. Sadock BJ & Sadock VA (2007) *Kaplan & Sadock's Synopsis of psychiatry 10th Ed* Philadelphia: Lippincott Williams & Wilkins.
32. Schwär TG, Olivier JA & Loubser JD (1988) *The forensic ABC in medical practice: a practical guide* Pretoria: Kagiso Publishers.
33. Shakespeare W *The merchant of Venice* (Verity AW ed) (1958) London: Cambridge University Press.
34. Simon RI & Hales RE (eds) (2006) *The American Psychiatric Publishing Textbook of suicide assessment and management* Washington, DC: American Psychiatric Publishing.
35. Strauss SA (1963) *Aspekte van die begrip "Toestemming" in die strafreg en die deliktereg: 'n regsvergelijkende studie met besondere verwysing na die verweer vrywillige aanvaarding van risiko* Pretoria: University of South Africa.
36. Strauss SA (1984) *Doctor, patient and the law, 2nd Ed* Pretoria: Van Schaik.
37. Strauss SA (1991) *Doctor, patient and the law: a selection of practical issues 3rd Ed* Pretoria: Van Schaik.
38. Strauss SA & Strydom MJ (1967) *Die Suid-Afrikaanse geneeskundige reg* Pretoria: Van Schaik.
39. Szasz TS (1972) *The myth of mental illness: foundations of a theory of personal conduct* London: Paladin Press.
40. Van der Walt JC & Midgley JR (2005) *Principles of delict 3rd Ed* Durban: Lexis Nexis.
41. Veatch RM (2003) *The basics of bioethics 2nd Ed* Upper Saddle River, New Jersey: Prentice Hall.
42. Waldinger RJ (1986) *Fundamentals of psychiatry* Washington: American Psychiatric Press.
43. Woolman S (2007) *Constitutional law of South Africa Student Edition* Cape Town: Juta.

44. World Health Organization (1992) *International statistical classification of diseases and related health problems 10th revision volume 1* Geneva: World Health Organization.
45. World Health Organization (1992) *International statistical classification of diseases and related health problems 10th revision volume 2* Geneva: World Health Organization.
46. World Health Organization (1992) *International statistical classification of diseases and related health problems 10th revision volume 3* Geneva: World Health Organization.

Case law: foreign

1. *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.
2. *Daubert v Merrell Dow Pharmaceuticals Inc.* 113 S. Ct. 2786 (1993).
3. *Frye v United States* 293 F. 1013 (D.C. Cir. 1923).
4. *R v M'Naghten* (1843) 8 ER 718.
5. *Rogers v Whitaker* (1993) 175 CLR 479.
6. *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 1 All ER 643.
7. *Tarasoff v Regents of the University of California* 83 ALR 3 rd 1166 (Cal 1976).

Case law: national

1. *Administrator, Natal v Edouard* 1990 (3) SA 581 (A).
2. *Barnard v Santam Bpk* 1999 (1) SA 202 (SCA).
3. *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A).
4. *Broude v McIntosh and Others* 1998 (3) SA 60 (SCA).
5. *Burger v Administrateur, Kaap* 1990 (1) SA 483 (C).
6. *C v Minister of Correctional Services* 1996 (4) SA 292.

7. *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC).
8. *Carmichele v Minister of Safety and Security and Another* 2003 (2) SA 656 (C).
9. *Castell v de Greef* 1993 (3) SA 501 (C).
10. *Castell v de Greef* 1994 (4) SA 408 (C).
11. *Christian Lawyers' Association v Minister of Health* 2005 (1) SA 509 (T).
12. *Clarke v Hurst* 1992 (4) SA 630 (D).
13. *Correira v Berwind* 1986 (4) SA 60 (ZH).
14. *Dube v Administrator, Transvaal* 1963 (4) SA 260 (W).
15. *Edouard v Administrator, Natal* 1989 (2) SA 368 (D).
16. *Esterhuizen v Administrator, Transvaal* 1957 3 SA 710 (T).
17. *Ex parte Dixie* 1950 4 SA 748 (W).
18. *Fose v The Minister of Safety and Security* 1997 (3) SA 786 (CC).
19. *Lampert v Hefer, NO* 1955 (2) SA 507 (A).
20. *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).
21. *Lymbery v Jefferies* 1925 AD 236.
22. *McCallum v Hallen* 1916 EDL 74.
23. *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA).
24. *Minister of Safety and Security and Another v Carmichele* 2004 (3) SA 305 (SCA).
25. *Minister of Safety and Security and Another v Gaqa* 2002 (1) SACR 654 (C).
26. *Minister of Safety and Security and Another v Xaba* 2004 (1) SACR 149 (D).
27. *Oldwage v Dr Louwrens* 2004 JDR 0023 (C).
28. *Palmer v Palmer* 1955 (3) SA 56(O).
29. *Prowse v Kaplan* 1933 EDL 257.
30. *R v Jolly and Others* 1923 AD 176.
31. *R v Matomana* 1938 EDL 128.
32. *R v McCoy* 1953 (2) SA 4 (SR).
33. *R v Von Zell* 1953 (3) SA 303 (A).
34. *Recsei's Estate v Meine* 1943 EDL 277.

35. *Richter and Another v Estate Hammann* 1976 (3) SA 226 (C).
36. *Road Accident Fund v Sauls* 2002 (2) SA 55 (SCA).
37. *Rompel v Botha* 1953 (T) (unreported).
38. *S v Collett* 1978 (3) SA 206 (RA).
39. *S v D* 1963 (3) SA 263 (E).
40. *S v Lehnberg* 1975 (4) SA 553 (A).
41. *S v Makwanyane and Another* 1995 (2) SACR 1 (CC).
42. *S v Marx* 1962 (1) SA 848 (N).
43. *S v Mnyanda* 1976 (2) SA 751 A.
44. *S v Nkwanyana* 2003 (1) SA 303 (W).
45. *S v Robinson and Others* 1968 (1) SA 666 (A).
46. *S v Sikunyana and Others* 1961 (3) SA 549 (E).
47. *SA Medical & Dental Council v McLoughlin* 1948 (2) SA 355 (A).
48. *SANTAM Insurance Co Ltd v Vorster* 1973 (4) SA 764 (A).
49. *Seema v Executive Member of Gauteng* 2002 (1) SA 771 (T).
50. *Seetal v Pravitha and Another NO* 1983 (3) SA 827 (D).
51. *Sibisi NO v Maitin* (311/13) [2014] ZASCA 156 1 October 2014.
52. *Stoffberg v Elliott* 1923 CPD 148.
53. *Van Eeden v Minister of Safety and Security* [2002] 4 All SA 346 (SCA).
54. *Van Wyk v Lewis* 1924 AD 438.
55. *Waring & Gillow Ltd v Sherborne* 1904 TS 340.
56. *Weber v SANTAM Versekeringsmaatskappy Bpk* 1983 (1) SA 381 (A).
57. *Zurnamer v Thielke* 1914 CPD 176.

Chapters in books

1. Abrams R 'Miscellaneous organic therapies' in Freedman AM, Kaplan HI & Sadock BJ (eds) (1976) *Kaplan & Sadock's Comprehensive textbook of psychiatry-II 2nd Edition Volume 2* 1987.
2. Bean P 'Violence and substance abuse' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 216.

3. Camus A 'Return to Tipasa' in Thody PMW (ed) (1970) *Lyrical and critical essays* 162.
4. Horton L 'Social, cultural and demographic factors in suicide' in Simon RI & Hales RE (eds) (2006) *The American Psychiatric Publishing Textbook of suicide assessment and management* 107.
5. Jacobs DG, Baldessarini RJ, Conwell Y, Fawcett JA, Horton L, Meltzer H, Pfeffer CR & Simon RI 'Appendix: APA Practice guideline for the assessment and treatment of patients with suicidal behaviours: Executive summary of recommendations' in Simon RI & Hales RE (eds) (2006) *The American Psychiatric Publishing Textbook of suicide assessment and management* 577.
6. Kaliski S 'Appendix: Mental health practitioners: the psychiatric professional nurse' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 382.
7. Kaliski S 'Appendix: Mental health practitioners: the psychiatrist' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 377.
8. Kaliski S 'Appendix: mental health practitioners: training issues' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 377.
9. Kaliski S 'Introduction' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 1.
10. Kaliski S 'The "dangerous offender" and risk assessment' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 113.
11. Kant I 'Fundamental principles of the metaphysic of morals' in Glickman J (ed) (1976) *Moral philosophy: an introduction* 392.
12. Lay S 'Appendix: mental health practitioners: the clinical psychologist' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 378.
13. McCord J 'Alcohol and dangerousness' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 195.
14. McQuoid-Mason D & Dhai A 'Health and human rights' in Dhai A & McQuoid-Mason (2011) *Bioethics, human rights and health law: principles and practice* 35.

15. Meloy JR 'Threats, stalking, and criminal harassment' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 238.
16. Mill JS 'Utilitarianism' in Glickman J (ed) (1976) *Moral philosophy: an introduction* 536.
17. Monahan J 'Major mental disorder and violence: Epidemiology and risk assessment' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 89.
18. Nöthling Slabbert M (2014) 'South Africa' in Nys H (ed) (2014) *International Encyclopaedia of Laws: Medical Law* 1.
19. Pagani L & Pinard G 'Clinical assessment of dangerousness: An overview of the literature' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 1.
20. Panieri Peter L 'The effects of alcohol and substances' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 126.
21. Potocnik F & Pienaar W 'The Elderly' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 721.
22. Prudic J 'Brain stimulation methods: Electroconvulsive therapy' in Sadock BJ, Sadock VA & Ruiz P (eds) (2009) *Kaplan & Sadock's Comprehensive textbook of psychiatry 9th Edition Volume II* 3285.
23. Simon RI 'Suicide risk: Assessing the unpredictable' in Simon RI & Hales RE (eds) (2006) *The American Psychiatric Publishing Textbook of suicide assessment and management* 1.
24. Tardiff K 'Axis I disorders and dangerousness' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 103.
25. Tiihonen J 'Recidivistic violent behaviour and Axis I and Axis II disorders' in Pinard G & Pagani L (eds) (2009) *Clinical assessment of dangerousness: empirical contributions* 121.
26. Zabow T 'The Mental Health Care Act (Act 17 of 2002)' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 58.

27. Zabow T & Kaliski S 'Ethical considerations' in Kaliski S (ed) (2007) *Psycholegal assessment in South Africa* 357.

Dictionaries and encyclopaedias

1. Dorland *Dorland's Illustrated Medical Dictionary 32nd Ed* (2012) Philadelphia: Elsevier, Saunders.
2. Soanes C & Stevenson A (eds) (2004) *Concise Oxford English Dictionary 11th Edition* New York: Oxford University Press.
3. Stedman, TL *Stedman's medical dictionary 28th Ed* (2006) Philadelphia: Lippincott Williams & Wilkins.

International law

1. Organization of African Unity (OAU) *African (Banjul) Charter on Human and Peoples' Rights* (1981), available at <http://www.achpr.org/instruments/achpr/> (accessed 31 October 2014).
2. United Nations *International Bill of Human Rights*, available at <http://www.ohchr.org/Documents/Publications/Compilation1.1en.pdf> (accessed 2 February 2015).
3. United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* adopted by the UN General Assembly Resolution 46/199 of 17 December 1991, available at <http://www.un.org/documents/ga/res/46/a46r119.htm> (accessed 2 October 2014).
4. United Nations (1948) *The Universal Declaration of Human Rights*, available at <http://www.un.org/en/documents/udhr/> (accessed 2 October 2014).
5. World Health Organisation, Division of Mental Health and Substance Abuse, *Mental Health Care Law: Ten Basic Principles* (WHO/MND/96.9), Geneva, 1996, available at

http://www.who.int/mental_health/policy/legislation/ten_basic_principles.pdf
(accessed 2 February 2015).

Internet sources

1. Alexander L & Moore M 'Deontological ethics' in Zalta EN (ed) *The Stanford Encyclopedia of Philosophy* (2012), available at <http://plato.stanford.edu/archives/win2012/entries/ethics-deontological/> (accessed 3 November 2014).
2. American Psychiatric Association (2014) *DSM-5 development*, available at <http://www.dsm5.org/Pages/Default.aspx> (accessed 7 August 2013).
3. Department of Justice and Constitutional Development *The end for Nyaope!*, available at <http://www.justice.gov.za/docs/articles/201405-Nyaope.pdf> (accessed 26 January 2015).
4. Frances A (2012) "DSM-5 Is a Guide, Not a Bible: Simply Ignore Its 10 Worst Changes" *HuffPost*, web log post, 12 March 2012, available at www.huffingtonpost.com/allen-frances/dsm-5_b_2227626.html (accessed 16 July 2014).
5. Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: National patients' rights charter* Pretoria: Health Professions Council of South Africa, available at http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_3_patients_rights_charter.pdf (accessed 29 October 2014).
6. Health Professions Council of South Africa (2008) *Guidelines for good practice in the health care professions: Seeking patients' informed consent: The ethical considerations* Pretoria: Health Professions Council of South Africa, available at http://www.hpcs.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_9_informed_consent.pdf (accessed 2 September 2014).

7. Insel T (2013) "Transforming diagnosis" *National Institute of Mental Health Director's Blog*, web log post, 29 April 2013, available at <http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml> (accessed 1 October 2014).
8. Johnson R 'Kant's Moral Philosophy' in Zalta EN (ed) *The Stanford Encyclopedia of Philosophy* (2008), available at <http://plato.stanford.edu/archives/sum2014/entries/kant-moral/> (accessed 3 November 2014).
9. *Open letter to the DSM-5*, available at <http://www.ipetitions.com/petition/dsm5/> (accessed 6 June 2014).
10. Sinnott-Armstrong W 'Consequentialism' in Zalta EN (ed) *The Stanford Encyclopedia of Philosophy* (2011), available at <http://plato.stanford.edu/archives/spr2014/entries/consequentialism/> (accessed 3 November 2014).
11. South African Society of Psychiatrists (SASOP) (2014) *CPD Meetings, Standard Operating Procedure* http://www.sasop.co.za/C_DC_CPDeve_meetings.asp (accessed 29 October 2014).
12. University of Pretoria, Faculty of Humanities, Department of Psychology (2014) *Booklet on Career opportunities with psychology as a discipline*, available at: <http://web.up.ac.za/sitefiles/file/46/1380/2014%20-%20Psych%20Booklets/2014%20-%20Psych%20Booklet%20-%20Eng.pdf> (accessed 1 July 2014).
13. Wilson F 'John Stuart Mill' in Zalta EN (ed) (2007) *The Stanford Encyclopedia of Philosophy*, available at <http://plato.stanford.edu/archives/spr2014/entries/mill/> (accessed 3 November 2014).
14. World Health Organization (2014) *Countries*, available at <http://www.who.int/countries/en/> (accessed 5 September 2014).
15. World Health Organization *Integrating mental health services into primary health care*, available at

http://www.who.int/mental_health/policy/services/3_MHintoPHC_Infosheet.pdf
(accessed 9 September 2014).

16. World Health Organization (2015) *International Statistical Classification of Diseases and Related Health Problems 10th Revision*, available at <http://apps.who.int/classifications/icd10/browse/2015/en> (accessed 7 January 2015).
17. World Health Organization (2014) *Mental disorders* available at http://www.who.int/topics/mental_disorders/en/ (accessed 1 October 2014).
18. World Health Organization (2014) *Mental Health*, available at http://www.who.int/topics/mental_health/en/ (accessed 12 September 2014).
19. World Health Organization (2014) *Preventing suicide: a global imperative* available at http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/ (accessed 30 October 2014).
20. World Health Organization (2014) *WHO Disability Assessment Schedule 2.0 (WHODAS 2.0)*, available at <http://www.who.int/classifications/icf/whodasii/en/> (accessed 1 October 2014).
21. World Psychiatric Association (2011) Madrid Declaration on Ethical Standards for Psychiatric Practice, available at http://www.wpanet.org/detail.php?section_id=5&content_id=48 (accessed 11 November 2014).
22. World Psychiatric Association *Member Societies*, available at http://www.wpanet.org/detail.php?section_id=5&content_id=674&sort_by=S (accessed 4 August 2014).

Journal articles

1. Allan A 'Psychiatric diagnosis in legal settings' (2005) 11 *South African Journal of Psychiatry* 52.
2. Allgulander C 'Understanding DSM-5: advice for South African practitioners' (2013) 16 *African Journal of Psychiatry* 321.

3. Behr GM, Christie C, Soderlund N & Lee T 'Patterns and determinants of acute psychiatric readmissions' (2002) 8 *South African Journal of Psychiatry* 71.
4. Berghmans RLP Widdershoven GAM 'Ethical perspectives on decision-making capacity and consent for treatment and research' (2003) 22 *Medicine and Law* 391.
5. Burns JK & Alonso-Betancourt O 'Are we slaves to DSM? A South African perspective' (2013) 16 *African Journal of Psychiatry* 151.
6. Freeman M 'New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health' (2002) *South African Psychiatry Review* 4.
7. Gendreau C 'The rights of psychiatric patients in the light of the principles announced by the United Nations: a recognition of the right to consent to treatment?' (1997) 20 *International Journal of Law and Psychiatry* 259.
8. Giesen D 'From paternalism to self-determination to shared decision making' (1988) *Acta Juridica* 107.
9. Kaliski S 'Will forensic psychiatry survive DSM-5?' (2012) 15 *African Journal of Psychiatry* 13.
10. Krüger C & Rosema D 'Risk factors for violence among long-term psychiatric in-patients: a comparison between violent and non-violent patients' (2010) 13 *African Journal of Psychiatry* 366.
11. Moodley SV, Matjila MJ & Moosa MYH 'Epidemiology of substance use among secondary school learners in Atteridgeville, Gauteng' (2012) 18 *South African Journal of Psychiatry* 2.
12. Moosa MYH & Jeenah FY 'Involuntary treatment of psychiatric patients in South Africa' (2008) 11 *African Journal of Psychiatry* 109.
13. Nienaber A 'The regulation of informed consent to participation in clinical research by mentally ill persons in South Africa: An overview' (2010) 16 *South African Journal of Psychiatry* 118.
14. Parmarand S 'The consenting plaintiff and the *boni mores*: the proper perspective' (1986) 3 *Journal of South African Law* 338.

15. Ramlall S 'The Mental Health Care Act No 17 – South Africa. Trials and triumphs: 2002 – 2012' (2012) 15 *African Journal of Psychiatry* 407.
16. Roffey M & Kaliski SZ 'To predict or not to predict – that is the question' An exploration of risk assessment in the context of South African forensic psychiatry (2012) 15 *African Journal of Psychiatry* 227.
17. Segal J & Thom R 'Consent procedures and electroconvulsive therapy in South Africa: impact of the Mental Health Care Act' (2006) 9 *South African Psychiatry Review* 206.
18. Strauss SA 'Bodily injury and the defence of consent' (1964) *South African Law Journal* 179.
19. Stein D 'Psychiatric classification, stigma and mental health' (2013) *African Journal of Psychiatry* 227.
20. Van Oosten FFW 'Castell v de Greef and the doctrine of informed consent: medical paternalism ousted in favour of patient autonomy' (1995) 28 *De Jure* 164.
21. Van Oosten 'Disclosure documents and informed consent: the pros and cons' (1993) *Medicine and Law* 651.
22. Van Oosten F 'The law and ethics of information and consent in medical research' (2000) 63 *Journal for Contemporary Roman-Dutch Law (THRHR)* 5.
23. Van Oosten 'The so-called 'therapeutic privilege' or 'contra-indication': its nature and role in non-disclosure cases' (1991) *Medicine and Law* 31.
24. Van Staden CW 'Can involuntarily admitted patients give informed consent to participation in research?' (2007) 13 *South African Journal of Psychiatry* 10.
25. Van Staden CW 'Mind, body and person: reviewing psychiatry's constituency' (2006) 9 *South African Psychiatry Review* 93.
26. Van Staden CW & Krüger C 'Incapacity to give informed consent owing to mental disorder' (2003) 29 *Journal of Medical Ethics* 41.
27. Wilson M 'When is a risk of medical treatment material?' (2006) *De Rebus* 22.
28. Zabow T 'Competence and decision-making: Ethics and clinical psychiatric practice' (2008) 1 *South African Journal of Bioethics and Law* 61.

Legislation

1. Children's Act 38 of 2005.
2. Choice on Termination of Pregnancy Act 92 of 1996.
3. Constitution of the Republic of South Africa, 1996.
4. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
5. Criminal Procedure Act 51 of 1977.
6. Drugs and Drug Trafficking Act 140 of 1992.
7. Health Professions Act 56 of 1974.
8. Mental Health Act 18 of 1973.
9. Mental Health Care Act 17 of 2002, as amended.
10. Mental Health Care Amendment Act 12 of 2014.
11. National Health Act 61 of 2003.
12. Nursing Act 33 of 2005.
13. Promotion of Access to Information Act 2 of 2000.
14. Social Services Professions Act 110 of 1978.
15. Sterilisation Act 44 of 1998.

Multimedia

1. Manson M (2003) '♠' *The Golden Age of Grotesque* California: Nothing.

Theses and dissertations

1. Carstens PA *Die strafregtelike en deliktuele aanspreeklikheid van die geneesheer op grond van nalatigheid* (LLD thesis) University of Pretoria (1996).
2. Stevens GP *The role of expert evidence in support of the defence of criminal incapacity* (LLD dissertation) University of Pretoria (2011).



3. Swanepoel M *Law, psychiatry and psychology: a selection of constitutional, medico-legal and liability issues* (LLD dissertation) UNISA (2009).
4. Van Oosten FFW *The doctrine of informed consent in medical law* (LLD thesis) UNISA (1989).