

Anaesthetists' knowledge of South African Law pertaining to informed consent in an academic centre

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Background: Anaesthetists require knowledge of informed consent laws to mitigate the risk of litigation. The knowledge of South African anaesthetists regarding informed consent law is unknown.

Methods: Participants from an academic anaesthetic department anonymously completed a researcher-developed questionnaire scored out of 23. Factors affecting questionnaire performance were recorded: years after graduation from medical school (YGMS); professional designation (PD); years of anaesthetic experience (YAE); and attendance at formal postgraduate training on informed consent (APGT).

Results: Data from 167 participants were included. The mean (SD) score achieved was 60.08% (12.61%). Questions assessing the Mental Health Care Act and the Children's Act achieved the highest 88.92% (22.23%) and lowest 51.82% (17.84%) mean scores respectively. Knowledge of the Choice of Termination of Pregnancy Act was poorer with increasing YGMS ($p = 0.0013$). Knowledge of the Children's Act correlated positively with PD ($p = 0.0004$), YAE ($p = 0.0180$) and APTG ($p = 0.0080$). Improved knowledge of the National Health Act correlated with higher PD ($p = 0.0120$). Knowledge of the Mental Health Care Act and of the Sterilisation Act worsened with increasing YGMS ($p = 0.0276$ and $p = 0.0108$ respectively). Mean questionnaire score improved with APTG ($p = 0.0161$) and higher PD ($p = 0.0163$).

Conclusion: Anaesthetists have suboptimal knowledge of informed consent laws. Anaesthetists should attend such training and postgraduate education institutions should run these courses regularly. Comparative studies should be conducted in other anaesthetic academic departments countrywide and include surgical staff.

Keywords: anaesthetist, informed consent, knowledge, law

Introduction

South African law, in particular the National Health Act No. 61 of 2003, specifies that informed consent is required prior to performing any procedure on a patient.¹ The administration of anaesthesia is considered to be a procedure; therefore, anaesthetists are expected to be familiar with laws governing informed consent.

Ethics and law are complementary processes used to guide the informed consent process by health professionals.

Although ethical principles must be adhered to, it is also essential that doctors have adequate knowledge of the laws regarding informed consent in the country in which they practise medicine. Being 'familiar with the law' and 'formal procedural regulations' should ensure that the doctor is carrying out his/her job correctly and providing a quality service to the patient, but also avoids unnecessary litigation, which may result from inappropriate or incorrect consent-taking practices.²

Unfortunately, knowledge of these laws is often taken for granted and, particularly at undergraduate level, teaching of these laws may be inadequate and highly variable between institutions. For example, a study by Zajdel *et al.*² examining the knowledge of medical law amongst allergists and pulmonologists in Poland discussed that the majority of medical staff had not had formal legal teaching prior to completion of their medical degrees. The same study noted that doctors depend heavily on external standards and do not appreciate that only the law is binding. A similar attitude is anecdotally present in South Africa.

In South Africa, the process of acquiring informed consent, including the relevant laws, is taught in undergraduate medical programmes. However, the knowledge that anaesthetists possess with regard to these processes and laws is not known. Naidu and Gopalan³ conducted a questionnaire-based study in KwaZulu-Natal examining the perspectives of anaesthetists on informed consent. They noted that 'the current process of obtaining informed consent for anaesthesia has been deemed ... to be substandard and legally indefensible'.³ This study raises the question of whether anaesthetists have adequate knowledge regarding informed consent.

In the same study by Naidu and Gopalan,³ two-thirds of doctors claimed that the risk of facing the law would alter their clinical practice. The Medical Protection Society (MPS) in South Africa has stated that 'over the past two years alone, the value of reported claims has more than doubled: an increase of 132%' and that the bulk of cost to the MPS is incurred via clinical negligence claims.⁴ Although the MPS data likely reflect claims related more to private practice, the bill for medical negligence claims within the public sector is also alarmingly high.⁵ In the United Kingdom, litigation against anaesthetists is increasing annually.⁶ Inadequate communication with patients is a strong contributor to these litigation statistics.⁷ The lack of adequate informed consent is considered to be a risk factor for subsequent medico-legal litigation brought against the practitioner.⁸

Adequate knowledge of the processes and laws regarding informed consent could help alleviate the burden of medico-legal litigation. In order to develop and adjust this aspect of

undergraduate and postgraduate anaesthesia curricula, an assessment of the current level of knowledge is necessary.

There is no published literature directly examining the knowledge of the South African laws pertaining to informed consent among trainee and qualified anaesthetists working in an academic department setting.

The aim of this study was therefore to describe the knowledge of anaesthetists working in an academic department affiliated to a university, regarding South African laws pertaining to informed consent. We tested for an association between the level of knowledge and years of anaesthetic experience, number of years after graduation from medical school and professional designation. We compared the level of knowledge between anaesthetists who had formal postgraduate teaching on informed consent with that of those who did not have such teaching.

Methods

Ethics and study design

Ethics clearance was received from the Wits Human Research Ethics Committee (Medical), clearance certificate number M160685.

This was a prospective, knowledge-based, contextual, descriptive and cross-sectional study using an anonymous self-administered questionnaire. Participation was voluntary and consent was implied on completion of the questionnaire. Care was taken to maintain the anaesthetists' anonymity and confidentiality and no identifying information was obtained from the participants.

Study setting and population

The study was conducted in the University of the Witwatersrand Department of Anaesthesiology in Johannesburg, South Africa. The department is affiliated with five teaching hospitals. Anaesthetists eligible for inclusion in the study included medical officers, registrars, career medical officers and consultants. In our department, a career medical officer is a medical officer with 10 or more years of experience who is employed in a position unlike that of a medical officer in training and functions in the capacity of a consultant despite not having passed the Fellowship of the College of Anaesthetists of South Africa FCA (SA) examinations. They have assumed honorary consultant positions. Interns were excluded as their presence in the department is transient (a two-month period) and the sample of interns at any one time may not be representative of the overall knowledge of interns in anaesthesia or of the Anaesthesia Department as a whole. Blank and illegible questionnaires were excluded, but were still used to calculate the response rate.

Questionnaire and conduct of the study

Data were collected using questionnaires distributed at departmental academic meetings. The chair was approached by the researcher for permission to address the attendees. All questionnaires were numbered to keep track of those completed and prevent reproduction of results. This also allowed for calculation of a response rate. Following an introduction to the study aim and objectives, the questionnaires were distributed to all the anaesthetists who attended the meetings and who wished to participate. The researcher was present to assist with queries and to prevent data contamination. Participants were given approximately 15–20 minutes to complete the questionnaire, which was then placed by the participant into a collection box

sited at the venue. Participants could not take the questionnaire with them and as a result data contamination was minimal if at all and answers could not be shared. Anonymity and confidentiality of the participants in the study was ensured as no personal identifying data were collected.

As no questionnaires regarding knowledge of South African law pertaining to informed consent had previously been published or validated, a questionnaire was developed by the researchers in collaboration with medical ethics experts within the discipline of anaesthesia and intensive care.

The questionnaire consisted of two sections:

- Section 1 acquired population characteristics, which included professional designation, years of experience in anaesthesiology, years after graduating from medical school and attendance at formal postgraduate teaching on informed consent.
- Section 2 consisted of 10 questions consisting of either 2 or 3 sub-questions resulting in 23 questions overall, marked out of a total score of 23. Each sub-question was a single correct answer multiple-choice question with a clinical vignette stem that tested a specific law. The questionnaire may be viewed as [Appendix 1](#). The laws that were assessed are listed in [Table 1](#).

The questionnaire was scored out of a total of 23, with one point allocated for each correct answer. Negative marking was not applied.

Sample size and statistical analysis

We calculated the preliminary sample size required using a web-based sample size calculator, Raosoft® (<http://www.raosoft.com/samplesize.html>).⁹ Using a margin of error of 5%, a 95% confidence interval, a total population size of 218 and a response distribution of 50%, the recommended minimum sample size was calculated as 140.

Data were analysed using SAS™ (SAS Institute, Cary, NC, USA).¹⁰

The association of knowledge of the law with years of experience, and years since graduation from medical school was analysed using Spearman's rank correlation test.

Knowledge comparisons between anaesthetists with and without formal postgraduate teaching on informed consent was analysed using a Wilcoxon–Mann–Whitney *U* test.

In this study, a *p*-value of < 0.05 was considered significant.

Table 1: Laws tested by question

Question	Law tested
1.1; 1.2	The Choice of Termination of Pregnancy Act No. 92 of 1996
2.1; 2.2 6.1; 6.2; 6.3 7.1; 7.2 8.1; 8.2 10.1; 10.2	The Children's Act No. 38 of 2005
3.1; 3.2; 5.1; 5.2; 5.3	The National Health Act No. 61 of 2003
4.1; 4.2	The Mental Health Care Act No. 17 of 2002
9.1; 9.2; 9.3	The Sterilisation Act No. 44 of 1998 (Amended 2005)

Table 2: Population data

Population characteristic		Number (%)
Professional designation	Medical Officer	27 (16%)
	1 st year registrar	17 (10%)
	2 nd year registrar	9 (5%)
	3 rd year registrar	27 (16%)
	4 th year registrar	21 (13%)
	Career medical officer/consultants	66 (40%)
Years of experience in anaesthesia	Less than one year	10 (6%)
	One to four years	59 (35%)
	Five to eight years	53 (32%)
	More than eight years	45 (27%)
Years after graduation from medical school	Less than four years	7 (4%)
	Four to eight years	60 (36%)
	Nine to 12 years	57 (34%)
	More than 12 years	43 (26%)
Attendance at formal postgraduate teaching on informed consent ^a	Attended	76 (46%)
	Did not attend	91 (54%)

^aFormal postgraduate teaching on informed consent is defined as a course/symposium or CPD accredited lecture on informed consent.

Results

A total of 218 anaesthetists met inclusion criteria within the department. One hundred and ninety-one attended the departmental academic meetings, encompassing the five teaching hospitals affiliated with the Wits anaesthesiology department. Each of these individuals received a questionnaire. One hundred and eighty-four questionnaires were returned, yielding an 84% response rate. Seventeen questionnaires were excluded due to incomplete demographic information. Therefore, 167 questionnaires were included in the final statistical analysis

($n = 167$). This sample size is well above the pre-defined expected sample size.

Table 2 gives the population characteristics of the total sample.

Of the 167 anaesthetists, none answered all questions correctly. The lowest individual score was 7 out of 23 (30.43%), while the highest individual score was 20 out of 23 (86.96%). The average score was 60.08%. The mean scores by law tested are summarised in Table 3.

Of the 23 questions, question 7.1 was the best answered question with 152 (91%) anaesthetists answering it correctly. This question tested the Children's Act No. 38 of 2005, specifically dealing with consent for medical and surgical treatment of a child.

Question 6.1 was the most poorly answered question, with 32 (19%) anaesthetists answering it correctly. This question tested the Children's Act No. 38 of 2005, specifically dealing with gaining consent for blood transfusion for a child in the setting of Jehovah's Witnesses.

Spearman's rank correlation test was used to test whether the performance on a question correlated with years since graduation from medical school; professional designation; years of anaesthetic experience; and attendance at formal postgraduate training on informed consent. These results are summarised in Table 4.

Overall, the mean (SD) score was 13.8204 (2.9006) out of a possible total of 23.

The median category of professional designation was fourth-year registrars, with a range that extended from medical officers to career medical officers/consultants.

Table 3: Mean score by law tested

Question	Law tested	Mean score % \pm SD
1	The Choice of Termination of Pregnancy Act No. 92 of 1996.	71.26 \pm 35.74
2, 6, 7, 8, 10	The Children's Act No. 38 of 2005.	51.82 \pm 17.84
3, 5	The National Health Act No. 61 of 2003.	59.52 \pm 21.84
4	The Mental Health Care Act No. 17 of 2002.	88.92 \pm 22.23
9	The Sterilisation Act No. 44 of 1998 (amended 2005).	64.67 \pm 26.31
Overall		60.08 \pm 12.61

Table 4: Spearman correlation coefficients comparing acts and variables

Score	Factors assessed (correlation coefficient; p -value)			
	PD	YAE	YGMS	APGT
The Choice of Termination of Pregnancy Act No. 92 of 1996	-0.02904; 0.7094	-0.12902; 0.0966	-0.24679; 0.0013*	0.04448; 0.5681
The Children's Act No. 38 of 2005	0.27107; 0.0004*	0.018292; 0.0180*	0.10164; 0.1912	0.20449; 0.0080*
The National Health Act No. 61 of 2003	0.19398; 0.0120*	0.12979; 0.0946	0.14422; 0.0630	0.05704; 0.4641
The Mental Health Care Act No. 17 of 2002	-0.11099; 0.1533	-0.11366; 0.1436	-0.17051; 0.0276	0.09097; 0.2423
The Sterilisation Act No. 44 of 1998 (amended 2005)	-0.14982; 0.0533	-0.12160; 0.1175	-0.19689; 0.0108*	0.01695; 0.8278
Overall percentage	0.018567; 0.0163*	0.08241; 0.2897	-0.01162; 0.8815	0.18606; 0.0161*

PD = professional designation; YAE = years of anaesthetic experience; YGMS = years since graduation from medical school; APGT = attendance at postgraduate training on informed consent.

*Denotes statistically significant ($p < 0.05$).

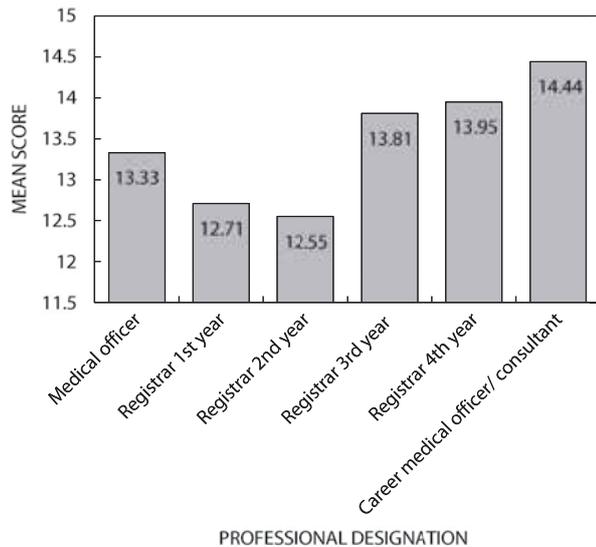


Figure 1: Mean score achieved as a function of professional designation.

The higher the anaesthetist's professional designation, the greater the mean score that was achieved ($p = 0.0163$).

Career medical officers/consultants had the highest mean score out of 23, followed by fourth-year registrars, third-year registrars, medical officers, first-year registrars and second-year registrars. These mean scores are graphically depicted in Figure 1.

The mode with regard to years of anaesthetic experience was five to eight years, with a range from less than one year to more than eight years. The greater the anaesthetist's number of years of anaesthetic experience, the better they scored on the questions that tested the Children's Act No. 38 of 2005 ($p = 0.0180$). Years of anaesthetic experience did not affect performance on any of the other Acts tested. There was no significant correlation between years of anaesthetic experience and mean score ($p = 0.2897$).

The mode with regard to years since graduation from medical school was 9 to 12 years, with a range that extended from less than 4 years to more than 12 years. The greater the number of years after graduating from medical school, the poorer candidates performed on questions testing the Choice of Termination of Pregnancy Act No. 92 of 1996 ($p = 0.0013$); the Mental Health Care Act No. 17 of 2002 ($p = 0.0276$); and the Sterilisation Act No. 44 of 1998 (amended 2005) ($p = 0.0108$). There was no significant correlation between years after graduating from medical school and overall mean score ($p = 0.8815$).

Seventy-six anaesthetists had attended formal postgraduate training on informed consent and scored a mean score (SD) of 14.41 out of 23 (2.95). The remainder, who had not received additional training, achieved a mean (SD) score of 13.33 (2.78). Those who had attended formal training fared better ($p = 0.0166$), with a difference in mean (SD) scores of 1.08 (2.86).

Attendance at formal postgraduate training was associated with improved performance in questions testing the Children's Act No. 38 of 2005 ($p = 0.0080$), and improved overall test performance ($p = 0.0161$).

Discussion

This is the first study solely examining South African anaesthetists' knowledge of the laws pertaining to informed consent. The average score of 60.09% (range 30.43%–86.96%) implies that the understanding of these laws is suboptimal as this infers that on average in only 6 in 10 situations is legally valid consent obtained. No pass mark was assigned to our questionnaire as it is not reasonable to make allowance for any deficiency in knowledge of these laws in the context of increasing litigation.

The scores and factors correlating with performance on the questions varied widely across the laws assessed.

The correlation between advancing years after graduation from medical school and lower scores on the questions assessing the Choice of Termination of Pregnancy Act No. 92 of 1996, as well as the Sterilisation Act No. 44 of 1998 (amended in 2005) is likely due to anaesthetists having little overall involvement in the termination of pregnancy and sterilisation procedures. An anaesthetic is not always required for these procedures, and when it is, it is often for more complicated cases only. Consequently, anaesthetists are less familiar with the Act that governs this process. Junior doctors may still possess knowledge from medical school, internship and community service regarding this Act. During these years, they have more interaction with obstetrics and gynaecology patients, and with increasing time away from this discipline these doctors may lose their knowledge of this law as their focus changes.

Knowledge of the Children's Act No. 38 of 2005 was inconsistent, as evidenced by varying scores in the questions assessing this. These questions produced the highest and lowest scores across the questionnaire. The factors that correlated with increased knowledge of this Act were seniority, increased anaesthetic experience and attendance at formal postgraduate teaching. This result is most likely due to regular (weekly) experience and ongoing training focused on paediatric surgical patients in our academic environment.

The questions assessing the National Health Act No. 61 of 2003 were consistently answered, except for knowledge regarding the specific priority list of individuals able to give consent on behalf of an incapacitated patient. It is interesting to note that most anaesthetists (98 out of 167) thought that the spouse/partner should be contacted first, followed by an adult child, a parent, grandparent, a person authorised by law or a court order and lastly a proxy mandated in writing. However, the correct sequence is a proxy mandated in writing by the patient, a person authorised by the law or a court order; spouse/partner; parent; grandparent; adult child and finally a sibling.¹

This suggests that most anaesthetists are not familiar with this part of the Act, and have applied what seems to be 'common sense'.

Anaesthetists scored lower on the questions assessing the Mental Health Care Act No. 17 of 2002 as they advanced in years after graduation from medical school. This is an expected finding, as anaesthetists are most likely to interact with mentally ill patients only when they present for electroconvulsive therapy, which is infrequent in our study setting.

On examining mean questionnaire scores in our study, the two factors correlating with a higher score were higher professional designation and attendance at formal postgraduate teaching on informed consent. This is in keeping with a study performed by Ashraf *et al.*¹¹ revealing considerable shortcomings in doctors' knowledge of surgical informed consent in Pakistan. As in our study, it was shown that junior doctors' knowledge was poorer than that of their more senior counterparts. This is particularly problematic as junior doctors are often tasked with obtaining consent.

However, Zajdel *et al.*² found in their Polish study that younger doctors had better knowledge of medical law than their older counterparts. This suggests that years of experience as a sole factor does not maintain or improve knowledge of medical law, but that more formal education such as specialisation or postgraduate course attendance is necessary to achieve this. In our study it was found that years of anaesthetic experience only correlated with a better performance on the questions that assessed the Children's Act No. 38 of 2005, with no overall effect on the other questions. This difference could be attributed to the fact that the Zajdel *et al.*² study examined knowledge of doctors in the private sector in Poland, which represents a different population.

There is little published literature on the knowledge of anaesthetists regarding medical law in South Africa. Chima¹² conducted a study in KwaZulu-Natal, examining the quality of informed consent across a range of specialties; 2.4% of the sample were anaesthetists. A question examining aspects of the National Health Act was answered poorly. In addition, consistent with our data, doctors with a higher professional designation performed better on the questionnaire. The author concludes that there is a deficiency in knowledge of local laws and recommends continuing education in medical law and ethics to address this problem.

A similar pattern is noted internationally. Leclercq *et al.*¹³ found that the knowledge of the surgical informed consent process in the Netherlands was suboptimal, and this was attributed to inadequate training. Fisher-Jeffes *et al.*¹⁴ note in their study focusing on British laws governing the consent-taking practices in children that doctors need to increase their knowledge on who is legally allowed to provide consent. In our study, we also found that knowledge of the Children's Act No. 38 of 2005 was the most inadequate of all the Acts assessed. A study performed in Croatia by Jukić *et al.*¹⁵ concluded that knowledge of the legal requirements for informed consent was also inadequate. This finding was echoed by Gupta *et al.*¹⁶ who found that the knowledge of informed consent amongst dentists in India was inadequate and further training would be needed. These conclusions are concerning and are also reflected by the data from our study.

Study limitations

This contextual study's findings are limited to anaesthetists assessed in one anaesthesiology academic department in the public health care sector. This study should be conducted in other contexts within South Africa. It is expected that performance on this questionnaire would be worse if the study were repeated in a non-academic environment; however, this should be confirmed by formal assessment.

The sample size of the study, while larger than expected, was not equally represented by anaesthetists from different professional

designations. The greatest representation was from career medical officers/consultants who comprised 40% of the sample. First- and third-year registrars each comprised 16% of the sample, fourth-year registrars comprised 13%, first-year registrars 10% and second-year registrars comprised the smallest proportion at 5%.

We could have looked at a separation of the category of consultants and career medical officers, as inclusion of consent ethics as part of the FCA (SA) curricula may impact on knowledge of ethics and the law. As career medical officers do not have an FCA (SA) certificate, it might have been interesting to note whether there was a knowledge difference in this regard.

There were sampling limitations present, the most notable of which was that the researcher relied on voluntary participation by departmental members. Further, it is potentially a limitation that anaesthetists who attended the departmental academic meetings where the study questionnaire was distributed were individuals more likely to show an interest in continuous learning and to seek CPD activities, and therefore had better knowledge than those who did not attend the meetings.

While the questionnaire was reviewed by two experts before being distributed to the anaesthetist sample group, it is not a standard questionnaire and may be open to misinterpretation of the questions leading to performance bias.

Some knowledge-based studies have post-test teaching on the subject being investigated and a follow-up questionnaire is then redistributed at a later date to determine whether there has been knowledge retention. As anonymity was ensured, this would have been difficult to conduct. It would not have been feasible to compare the pre- and post-test questionnaire data to determine whether there was knowledge retention by specific participants.

Conclusion

We found that the knowledge of anaesthetists regarding South African law pertaining to informed consent is suboptimal. It is concerning that anaesthetists scored lowest on questions assessing knowledge of the Children's Act and the National Health Act.

This could be due to inadequate training at an undergraduate level; lack of a formal subject on ethics and medical law in undergraduate curricula; no requirement for certification in ethics and medical law for doctors; and lack of continuing education on the law during the postgraduate phase. There is also, in the authors' opinion, a lack of interest in the subject matter, and many do not deem it important enough to focus on.

While these reasons may exist, lack of sound knowledge not only does a disservice to the patient but undermines the doctor's professional integrity and sets up a real risk of litigation.

The attainment of informed consent from the patient is a constitutionally protected right in South Africa.¹² The consent of the patient is required for any lawful medical intervention, and this is a sanctioned part of South African law.¹²

While it is not the task of the anaesthetist to acquire surgical informed consent, it is the duty of the anaesthesia provider to ensure that consent is legally valid for both the administration of the anaesthetic and the performance of the surgical

procedure. Inappropriately or incorrectly taken consent is legally indefensible.

It would be interesting to repeat this study comparing the knowledge of anaesthetists and surgeons in different disciplines. Furthermore, a study comprising questions based purely on consent for anaesthetic services could be conducted.

The results of this study highlight the knowledge deficits of anaesthetists regarding consent law. We recommend that active intervention be undertaken by medical schools, specialist programme directors, the Colleges of Medicine of South Africa and the Health Professions Council of South Africa to address this problem.

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Appendix 1: Questionnaire and memorandum

Questionnaire

SECTION 1:

Please provide the following information by use of the tick box:

Professional designation:	Medical Officer	<input type="checkbox"/>
	Registrar 1 st year	<input type="checkbox"/>
	Registrar 2 nd year	<input type="checkbox"/>
	Registrar 3 rd year	<input type="checkbox"/>
	Registrar 4 th year	<input type="checkbox"/>
	Career Medical Officer or Consultant	<input type="checkbox"/>

Years of experience in anaesthesia: _____ years.

Years since graduation from medical school _____ years.

Have you attended formal postgraduate teaching (course/symposium/CPD accredited lecture) on informed consent?

Yes No

SECTION 2:

Question 1

Indicate the correct answer with an 'x' in the appropriate box provided. There is one correct answer per question.

An 11-year-old girl presents to the clinic requesting a termination of pregnancy.

1.1 Which one of the following is correct?

- a) She may not consent to the procedure
- b) She may consent to the procedure. Her parent/guardian is required to provide assent to the procedure
- c) She may consent to the procedure. Her parent/guardian is not required to provide assent to the procedure
- d) She may consent to the procedure but her parent/guardian is required to give consent to the procedure as well

a	b	c	d
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1.2 Knowledge of which Act is being tested in the above scenario?

- a) Children's Act
- b) Child Care Act
- c) Choice of Termination of Pregnancy Act
- d) National Health Act

a	b	c	d
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Question 2

A 13-year-old girl presents to the clinic requesting an HIV test

2.1 Which of the following is correct?

- a) She may consent with proper pre- and post-test counselling
- b) She may consent with proper pre- and post-test counselling. Her parents are required to provide consent as well
- c) She may consent to the procedure with proper pre- and post-test counselling. Her parents are required to provide assent as well
- d) She cannot consent to the procedure

a	b	c	d
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2.2 Which law is the above scenario testing?

- a) Children's Act
- b) Child Care Act
- c) Health Professions Amendment Act
- d) National Health Act

a	b	c	d
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Question 3

You have provided a general anaesthetic to a 49-year-old male patient who presented to theatre for an emergency fracture reduction. After inserting a second intravenous line intraoperatively, you accidentally prick yourself with the contaminated needle. You check his file and his HIV status is not documented. He is wasted and has oral thrush. When he awakens from anaesthesia and is fully alert, he tells you he does not know his HIV status. You fully explain the situation to him and counsel him well. He refuses to provide his consent to an HIV test despite this.

3.1 Which of the following is correct?

- a) You may draw a blood sample on the pretence of testing for another parameter and run the HIV test at the lab without the patient's knowledge or consent
- b) You may test the patient without his informed consent if an existing blood sample is available.
- c) You ask for the patient to be restrained and proceed to draw the blood for the HIV test
- d) You assume the patient to be HIV-positive and start taking post-exposure prophylaxis

a	b	c	d
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The same patient in the above scenario is transferred intubated and ventilated to ICU postoperatively.

3.2 How would you attempt to get consent for the HIV test in this situation?

- a) You take the blood sample anyway as he is intubated and he won't know about it when he wakes up in ICU

- b) You attempt to get proxy consent by a person legally able to give consent
- c) You attempt to get consent from the head of the orthopaedic unit the patient belongs to
- d) You attempt to get consent from the CEO of the hospital

a	b	c	d
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Question 4

A depressed and suicidal 57-year-old female is admitted by the psychiatry department. The registrar calls you to book the patient for an electroconvulsive therapy session the following day. She says that the patient is refusing to give consent. She says in this circumstance consent is not required as she is not of sound mind to understand the benefits of the procedure.

4.1 Which of the following is correct?

- a) You agree to proceed without the patient's informed consent
- b) Consent should be obtained from a proxy, the court or a mental review board
- c) Consent should be obtained from the head of the psychiatry unit
- d) Consent should be obtained from the CEO of the hospital

a	b	c	d
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4.2 Which law is this in accordance with?

- a) Health Professions Amendment Act
- b) Mental Health Care Act
- c) National Health Act
- d) Primary Health Care Act

a	b	c	d
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Question 5

An 80-year-old woman who was previously well slipped at her old age home and fractured her neck of femur. Upon examination she is noted to be confused. She cannot give consent to an ORIF of her femur as she is delirious. When the orthopaedic surgeon books the case with you, he notes that he is unsure of who he should contact first to get consent.

5.1 He should attempt to contact these people, in the following order:

- a) A proxy mandated in writing, a person authorised by law or a court order, the spouse/partner, the parent, the grandparent, the adult child, the brother/sister
- b) A person authorised by law or a court order, the spouse/partner, the parent, the adult child, the grandparent, the brother/sister, a proxy mandated in writing
- c) The adult child, the spouse/partner, the brother/sister/the parent, the grandparent, a proxy mandated in writing, a person authorised by law or a court order

- d) The spouse/partner, the adult child, the brother/sister, the parent, the grandparent, a person authorised by law or a court order, a proxy mandated in writing

a	b	c	d
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5.2 Which Act is being tested in the above scenario?

- a) Health Professions Amendment Act
- b) Mental Health Care Act
- c) National Health Act
- d) Primary Health Care Act

a	b	c	d
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The 50-year-old daughter of this patient is contacted and she refuses to give consent for surgery, despite being counselled about the risks and benefit of such, saying that she prefers her mum to be in bed in skin traction and doesn't want her to undergo any form of surgery. It is noted after a multidisciplinary team meeting that her surgery can be delayed.

5.3 Which of the following options is most appropriate?

- a) He may seek legal advice and apply for a court order
- b) He may go ahead despite the daughter's refusal on the basis that she doesn't have sufficient medical knowledge to make the correct decision
- c) He may apply for consent from the CEO
- d) The patient should be approached for consent once the delirium has resolved.

a	b	c	d
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Question 6

A 9-year-old child presents to theatre with a fractured tibia/fibula after being run over by a taxi while playing in the street. The child requires a blood transfusion. The child's parents inform you that they are Jehovah's Witnesses. You counsel them extensively but they are adamant that they will not allow their child to be transfused or consider alternative therapy.

6.1 What is your recourse?

- a) Ask the child if he is willing to have a blood transfusion and proceed with the transfusion if he agrees
- b) Accept the parents' choice and proceed as best as possible without transfusing the child
- c) You may act in the child's best interests which is to ignore the parents' wishes and proceed with the blood transfusion as this is an emergency
- d) Obtain a court order to allow a transfusion as long as it is in the best interest of the child

a	b	c	d
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Another 9-year-old Jehovah's Witness is booked for elective surgery which potentially will require a blood transfusion. The blood transfusion is not an emergency and the parents refuse the transfusion or alternatives.

6.2 What is your plan of action?

- a) Ask the child if he is willing to have a blood transfusion and proceed with the transfusion intraoperatively as needed
- b) Accept the parents' choice and proceed as best as possible without transfusing the child intraoperatively
- c) You may act in the child's best interests which is to ignore the parents' wishes and proceed with the blood transfusion during the operation as the need arises
- d) Obtain a court order to allow for a transfusion as long as it is in the best interest of the child

a	b	c	d
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6.3 Which law is the above scenario testing?

- a) Children's Act
- b) Child Care Act
- c) Health Professions Amendment Act
- d) National Health Act

a	b	c	d
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Question 7:

A 12-year-old girl brings her 4-week-old infant to paediatric OPD with symptoms of projectile vomiting. Pyloric stenosis is confirmed. The paediatric surgeon wonders if it is acceptable to get consent from the mother as she is just 12 years old, although she seems mature enough to understand the required surgical treatment.

7.1 Which of the following is correct?

- a) She may consent to the medical and surgical treatment of her infant, but she should be assisted by someone who has parental responsibility over her
- b) She may not consent to the medical and surgical treatment of her infant, and her mother, i.e. the infant's grandmother, must provide consent
- c) She may not consent to the treatment of her infant and a court order must be obtained for consent
- d) She may not consent to the treatment of her infant and the head of the paediatric unit or the CEO of the hospital must provide consent

a	b	c	d
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7.2 Which law is the above scenario testing?

- a) Children's Act
- b) Child Care Act
- c) Health Professions Amendment Act
- d) National Health Act

a	b	c	d
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Question 8

A 12-year-old child presents to hospital with her parents complaining of right iliac fossa pain and vomiting for the last 2 days. She is diagnosed with acute appendicitis requiring an appendectomy.

8.1 Which of the following is correct?

- a) The child may consent to the operation if she is of sufficient maturity to do so. The parents' consent should also be obtained
- b) The child's parents must give consent to the surgery and the child may provide assent
- c) Only the child's parents are required to provide consent
- d) The child may consent to the operation if she is of sufficient maturity to do so. The parents' assent should also be obtained

a	b	c	d
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8.2 Which law is the above scenario testing?

- a) Children's Act
- b) Child Care Act
- c) Health Professions Amendment Act
- d) National Health Act

a	b	c	d
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Question 9

An 18-year-old female presents to your Obstetric Theatre for an elective Caesarean section for twin pregnancy. She has requested a sterilisation to be performed at the same time as her Caesarean section. She says she is married and she and her husband do not want more children, neither do they wish to make use of other contraceptive methods. The obstetrician has told her she is too young and she may not have a sterilisation.

9.1 What is the patient's recourse?

- a) She may consent to the sterilisation
- b) She may not consent to the sterilisation due to her age
- c) She may consent to the sterilisation provided her partner gives his consent as well
- d) She may consent to the sterilisation provided her partner gives assent

a	b	c	d
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9.2 Which Act is being tested in the scenario above?

- a) Health Professions Amendment Act
- b) National Health Act
- c) Primary Health Care Act
- d) Sterilisation Act and Amendment Act

a	b	c	d
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An 18-year-old female with severe mental retardation and cerebral palsy is booked for a sterilisation as no other appropriate contraception can be provided. The patient will not be able to fulfil parental responsibility, nor will she develop further to make an informed decision about contraception or sterilisation.

9.3 What provisos are there for consent to be valid in terms of law?

- a) The parent/guardian/spouse/curator of the patient may provide consent to the procedure after application to the head of the hospital who will convene a panel of three healthcare professionals to consider the case
- b) The parent/guardian/spouse/curator of the patient may provide consent to the procedure without application to the head of the hospital or the convening of a panel to consider the case
- c) Application should be made to the head of the hospital who may provide consent to the procedure after convening a panel of three healthcare professionals to consider the case
- d) The treating doctor can provide consent on behalf of the patient as the procedure is in the patient's best interest

a	b	c	d
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Question 10

An 11-year-old girl with Down's Syndrome (Trisomy 21) is booked on your ENT list for today for tonsillectomy and adenoidectomy. She attends a learning centre every day and seems to be of reasonable intelligence to understand the procedure.

The girl's parents are contacted. Her biological father refuses to give consent for the tonsillectomy and adenoidectomy after he is informed of the risks. He was never married to nor lived with the girl's mother. He also does not contribute to the child's upkeep. The child is fully informed of the procedure. The biological mother, however, gives her consent for the procedure.

10.1 Who can provide consent for the procedure?

- a) The biological mother can give consent alone as she has full parental responsibility
- b) The biological mother and father must both consent to the procedure for it to go ahead
- c) The father's refusal negates the mother's consent
- d) Another proxy or a court order should be sought due to the parental conflict

a	b	c	d
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10.2 Which Act is being tested in the above scenario?

- a) Children's Act
- b) Child Care Act
- c) Mental Health Care Act
- d) National Health Act

a	b	c	d
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SECTION 3: Memorandum

QUESTION	CORRECT ANSWER
1.1	c
1.2	c
2.1	a
2.2	a
3.1	d
3.2	b
4.1	b
4.2	b
5.1	a
5.2	c
5.3	d

(Continued)

Continued.

QUESTION	CORRECT ANSWER
6.1	c
6.2	d
6.3	a
7.1	a
7.2	a
8.1	d
8.2	a
9.1	a
9.2	d
9.3	a
10.1	a
10.2	a