

# Involuntary contraceptive sterilisation of women in South Africa and the criminal law

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## ABSTRACT

The Sterilisation Act 44 of 1998 prohibits sterilisations without informed consent. Despite its enactment, people are being involuntarily sterilised in South Africa and women are reportedly disproportionately affected by this practice. An involuntary sterilisation violates a number of human rights and is recognised as a form of gender-based violence. On this basis, the article emphasises the role of the state to investigate and prosecute instances of involuntary sterilisations. It identifies s 9, read together with ss 2 and 4 of the Sterilisation Act 44 of 1998 and the common-law crime of assault as relevant crimes being perpetrated when a woman is involuntarily sterilised and considers when and how each crime is applicable. The article also recognises the complexity of consent-acquiring practices in the context of reproductive health care and considers criminal liability of different health care providers in relation to refusal to consent, coercion and signed consent forms. These issues need increased consideration because, to date, no health care provider has been held criminally liable for treatment without consent and there is no reported case law demonstrating how to apply criminal-law principles to this area of concern.

## 1 Introduction

Voluntary sterilisation is one of the most widely used forms of contraception and as such, access to this reproductive health care service supports the realisation of freedom of reproductive choice and promotes the right to bodily and psychological integrity, reproductive health, dignity and equality for many people.<sup>1</sup> Supportive of a human rights approach, many countries have enacted legislation which promotes reproductive self-determination via the statutory inclusion of stringent informed consent requirements for purposes of sterilisation.<sup>2</sup>

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<sup>1</sup> See World Health Organization *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement*, 2014, available at [http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf?ua=1), accessed on 28 February 2016.

<sup>2</sup> Ibid.

However, despite having a rights-affirming approach to sterilisations, there continues to be widespread reports of coerced or forced sterilisations (involuntary sterilisations)<sup>3</sup> across the globe, and women and girls are reportedly disproportionately affected by this practice.<sup>4</sup>

In 2011, the International Federation of Gynecology and Obstetrics recognised that sterilising women without their informed consent 'constitutes an act of violence, whether committed by individual practitioners or under institutional or governmental policies'.<sup>5</sup> More specifically, involuntary sterilisation of women is identified as a form of obstetric violence,<sup>6</sup> which is a form of gender-based violence.<sup>7</sup> Recognising involuntary sterilisation as a form of violence perpetrated against women is significant because it positions this issue within the broader pressures and obligations placed on states by international instruments and organisations to actively address violence through investigating reports of violence and prosecuting perpetrators.<sup>8</sup>

This article is inspired by the call to prosecute those who carry out involuntary sterilisations, as a form of violence against women. It is noted that while there is a demand for prosecutions, there is very little

<sup>3</sup> Sterilisations are classified as involuntary when no consent is obtained or when the consent provided is invalid as a result of coercion, lack of capacity or duress. See Women's Legal Centre 'A simplified guide to sterilisation and your rights', *Women's Legal Centre*, 2015, available at <http://www.wlce.co.za/images/health/know%20your%20rights-sterilisation%20booklet-final.pdf>, accessed on 28 January 2016. Involuntary sterilisation is used to describe those sterilisations that are forced or coerced.

<sup>4</sup> World Health Organization op cit (n1) 3.

<sup>5</sup> See art 5 of the International Federation of Gynecology and Obstetrics 'Female contraceptive sterilization' 2011, available at [http://www.womenenabled.org/pdfs/International\\_Federation\\_of\\_Gynecology\\_and\\_Obstetrics\\_Sterilization\\_Guidelines\\_FIGO\\_2011.pdf?atredirects=0](http://www.womenenabled.org/pdfs/International_Federation_of_Gynecology_and_Obstetrics_Sterilization_Guidelines_FIGO_2011.pdf?atredirects=0), accessed on 28 February 2016.

<sup>6</sup> See art 15 of the Venezuelan Organic Law on Women's Rights for a Life Free of Violence (2007), obstetric violence is defined as the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanised treatment, an abuse of medication, and includes converting natural processes into pathological ones. This causes a loss of autonomy. See also P D'Gregorio 'Obstetric violence: A new legal term introduced in Venezuela' (2010) 111 *Internat'l J Gynecology & Obstetrics* 201; M Gonzalez-Flores 'Resistance of Mayan women against obstetric violence' (2015) 3 *Global Societies Jnl* 1 at 5 and C Pickles 'Eliminating abusive "care": A criminal law response to obstetric violence in South Africa' (2015) 54 *S Af Crime Q* 5.

<sup>7</sup> See generally LZ Dixon 'Obstetrics in a time of violence: Mexican midwives critique routine hospital practices' (2015) 29 *Medical Anthropol'y Q* 437.

<sup>8</sup> For instance, see World Health Organization op cit (n1) 12; arts 16, 18, 31 and 45 of the Addis Ababa Declaration on Population and Development in Africa beyond 2014 (2013) and arts 3, 4 and 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003). On how this approach has succeeded in Latin America, see generally Dixon op cit (n7) where legislation was enacted to address obstetric violence.

discussion about what crime or crimes perpetrators should or could be prosecuted for. This is an important consideration because research demonstrates that criminal prosecutions for involuntary sterilisations tend to fail,<sup>9</sup> and the primary mode of recourse for women is civil action.<sup>10</sup>

This article seeks to fill this gap but from a South African perspective, particularly in the light of recent reports of the alleged involuntary sterilisation of women living with human immunodeficiency virus (HIV) in South Africa.<sup>11</sup> Ultimately, the article aims to contribute to the broader discourse against involuntary sterilisations; it identifies relevant crimes and demonstrates *how* these crimes can be applied to this context.<sup>12</sup> Emphasising the role of the criminal law draws attention to the fact that an involuntary sterilisation is not only a personal harm, but a public harm too, and it highlights obligations placed on the state to act.<sup>13</sup>

The article starts by considering women's lived experiences of involuntary sterilisations in South Africa and contemporary legal responses thereto, and it emphasises the insufficiency of those responses. It then identifies s 9, read together with ss 2 and 4, of the Sterilisation Act 44 of 1998 and the common-law crime of assault as the relevant crimes applicable to involuntary sterilisations. From there, the article explores how these crimes can be applied within the reproductive health care setting and in relation to consent requirements. The article reveals that consent-acquiring practices in reproductive health care is complicated because of the involvement of numerous role players, but that criminal liability can be established nonetheless.

<sup>9</sup> M Kopalová 'Coercive sterilisation in Czech Republic: Civil and criminal law aspects' (2006) 11 *Roma Rights Qy* 27 and G Albert 'Forced sterilization and Romani women's resistance in central Europe' (2011) 71 *Different Takes* 1.

<sup>10</sup> Personal communication with Ann Strode, 11 January 2016; *Isaacs v Pandie* [2012] ZAWCHC 47; *Pandie v Isaacs* (A135/2013, 1221/2007), [2013] ZAWCHC 123 (4 September 2013); *Government of the Republic of Namibia v LM* (SA 49/2012), [2014] NASC 19; P Nair 'Litigating against forced sterilization of HIV-positive women: Recent developments in Chile and Namibia' (2010) 23 *Harv J* 223; Albert op cit (n9); and C Zampas and A Lamacková 'Forced and coerced sterilization of women in Europe' (2011) 114 *Internat'l J Gynecology & Obstetrics* 163.

<sup>11</sup> See A Strode, S Mthembu and Z Essack "'She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012) 20(39) *Reproductive Health Matters* at 61 and South African National AIDS Council 'The People living with HIV stigma index, South Africa: Summary report', *South African National AIDS Council*, 2015, available at <file:///C:/Users/User/Downloads/Abridged%20Stigma%20Index%20Report.pdf>, accessed on 28 January 2016.

<sup>12</sup> Some of the arguments presented herein may support the introduction of prosecutorial guidelines; however, prosecutorial guidelines and the content thereof fall beyond the aims of this article and will not be considered.

<sup>13</sup> See section 2 of the article below.

Three issues are explored (as derived from those reported experiences of involuntary sterilisations), namely, refusal to consent, the value of a signed consent form and whether even subtle coercion is sufficient to render consent invalid. To date, these issues have not been fully scrutinised and it is hoped that these findings are useful to further the issue, or even encourage criminal prosecutions.

## 2 Involuntary sterilisations in South Africa and current legal responses

In South Africa, the Sterilisation Act 44 of 1998 regulates sterilisations. According to s 1 ‘sterilisation’ means ‘a surgical procedure performed for the purpose of making the person on whom it is performed incapable of procreation, but does not include the removal of any gonad’. The Act provides that a person may not be sterilised without his or her informed, voluntary and written consent and it recognises the right of a patient to withdraw consent at any time before commencement of the sterilisation procedure.<sup>14</sup> This legislative framework protects and promotes patient autonomy and the rights to bodily and psychological integrity, including the right to make reproductive decisions, and to security and control over one’s body.<sup>15</sup> It also safeguards the right to dignity<sup>16</sup> to the extent that the Act ensures that sterilisation decisions are made in an environment of accountability and respect.<sup>17</sup>

Despite this established framework, there are allegations of involuntary sterilisations throughout South Africa.<sup>18</sup> In 2012, Strode, Mthembu and Essack published an explorative study that identified 22 women living with HIV who were involuntarily sterilised in Gauteng and KwaZulu-Natal.<sup>19</sup> In March 2015, women’s advocacy organisations lodged a complaint at the Commission for Gender Equality concerning the involuntary sterilisation of 48 HIV-positive women in Gauteng and KwaZulu-Natal during 1986-2014.<sup>20</sup> Later that same year, the South African National AIDS Council released a study conducted to measure the levels of stigma and discrimination experienced by people living

<sup>14</sup> See ss 2 and 4 of the Sterilisation Act 44 of 1998.

<sup>15</sup> Section 12 of the Constitution of the Republic of South Africa, 1996.

<sup>16</sup> Section 10 of the Constitution of the Republic of South Africa, 1996.

<sup>17</sup> Preamble to the Sterilisation Act 44 of 1998.

<sup>18</sup> See Strode, Mthembu and Essack op cit (n11) 61 and South African National AIDS Council op cit (n11).

<sup>19</sup> Op cit (n11). The study documents their lived experiences of involuntary sterilisations and juxtaposes these experiences against the requirements of the Sterilisation Act 44 of 1998 and broader constitutional principles.

<sup>20</sup> J Koka “‘Forced’ sterilisation of HIV positive women violates rights”, *Mail & Guardian*, 19 March 2015, available at <http://mg.co.za/article/2015-03-19-forced-sterilisation-of-hiv-women-violates-rights>, accessed on 28 January 2016.

with HIV in South Africa.<sup>21</sup> The council interviewed 10 473 people living with HIV and found that 7% (roughly 733) of interviewees were forcibly sterilised throughout South Africa.<sup>22</sup> Many more people may be sterilised but are unaware of their reproductive capacity because of the devious approach adopted by some health care providers (doctors and nurses), rendering these figures a mere glimpse into a larger problem of human rights violations.

Involuntary sterilisations were found to take place when women were in the process of accessing other forms of reproductive health care services such as termination of pregnancy services and hospital births.<sup>23</sup> In some instances women signed consent forms without knowing what they were signing or without any explanation, and in other instances, women signed consent forms under duress.<sup>24</sup> The women were found to be under duress because they signed consent forms when they were already in the throes of labour, on their way to the operating theatre for purposes of performing a caesarean-section delivery, or were refused obstetric care or access to other services unless they signed a sterilisation consent form.<sup>25</sup> At times, women were provided with false information about the benefits of sterilisation or they were not informed of alternative contraceptive options, and in some instances the consequences, risks and nature of the procedure (reversible or irreversible) were not explained.<sup>26</sup> Strode, Mthembu and Essack also found that none of the women were informed that they had the right to refuse to be sterilised.<sup>27</sup>

These experiences indicate that while patients had signed consent forms, the consent was not voluntary and/or informed, thus rendering the sterilisations involuntary and unlawful. All the women who participated in Strode, Mthembu and Essack's study were provided with legal advice.<sup>28</sup> According to Strode, one matter was settled out of court, two matters are before the high court and legal representatives

<sup>21</sup> Op cit (n11) 20.

<sup>22</sup> The report does not indicate how it defines forced sterilisations nor how many interviewees were male or female. Media coverage of the study reported that an estimated 489 of those sterilised were women. See J Matroos 'WC to investigate forced sterilisations' *SA Breaking News*, 11 June 2015, available at <http://www.sabreakingnews.co.za/2015/06/11/wc-to-investigate-forced-sterilisations/>, accessed on 28 January 2016.

<sup>23</sup> Strode, Mthembu and Essack op cit (n11) 6; *Isaacs v Pandie* supra (n10); and *Pandie v Isaacs* supra (n10).

<sup>24</sup> Strode, Mthembu and Essack op cit (n11) 65-66.

<sup>25</sup> Strode, Mthembu and Essack op cit (n11) 65.

<sup>26</sup> Strode, Mthembu and Essack op cit (n11) 63-64.

<sup>27</sup> *Ibid.*

<sup>28</sup> Z Essack and A Strode "I feel like half a woman all the time": The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' (2012) 26 *Agenda* 24 at 27.

have lodged a complaint with the Commission for Gender Equality for all those cases that have prescribed.<sup>29</sup> There were no criminal charges laid.

It is noticeable that the primary method of recourse for involuntary sterilisation concerns public activism and/or civil litigation.<sup>30</sup> There is very little research available about the possible crimes being committed when women are involuntarily sterilised. Where criminal prosecution is initiated in other jurisdictions, it tends to be reported as unsuccessful and no information is provided explaining what crimes were committed by whom or why criminal prosecution was unsuccessful.<sup>31</sup>

The role of the criminal law must be properly considered for a number of reasons. Involuntary sterilisations can be viewed as a form of public harm because performing medical procedures on a certain group within society without consent is physically invasive and a grave violation of the right to bodily and psychological integrity,<sup>32</sup> and deserves punishment.<sup>33</sup> The state is obligated to promote, protect and fulfil the rights in the Bill of Rights.<sup>34</sup> Thus, the state and its organs are first in line regarding the duty to act in cases of human rights violations. Furthermore, recognising involuntary sterilisations as a form of obstetric violence (a gender-based violence) situates this issue

<sup>29</sup> Personal communication with Ann Strode, 11 January 2016.

<sup>30</sup> Ibid; *Isaacs v Pandie* supra (n10); *Pandie v Isaacs* supra (n10); *Government of the Republic of Namibia v LM* supra (n10); Nair op cit (n10); and Albert op cit (n9).

<sup>31</sup> Centre for Reproductive Rights 'Litigation briefing series: FS v Chile', *Centre for Reproductive Rights*, December 2010, available at [http://www.reproductiverights.org/sites/crr.civicactions.net/files/flash/Toolkit%20-%20FS%20v.%20Chile%20\(Dec.%202010\).PDF](http://www.reproductiverights.org/sites/crr.civicactions.net/files/flash/Toolkit%20-%20FS%20v.%20Chile%20(Dec.%202010).PDF), accessed on 28 January 2016 and Nair op cit (n10) 2. However, in the Czech Republic, criminal prosecution did not take place because 'a crime had not occurred'. See Kopalová op cit (n9) 28. This emphasises the importance of clarifying how to apply the criminal law.

<sup>32</sup> This right is protected in terms of s 12(2)(a) and (b) of the Constitution of the Republic of South Africa, 1996.

<sup>33</sup> According to A Ashworth and J Haorder *Principles of Criminal Law* 7ed (2013) 28-29, the harm principle assists with determining reasons for and against criminalising certain conduct which results in a harm. While the definition of 'harm' is debatable, the harm principle supports the notion that the state should criminalise conduct that causes or creates the risk of harm to others. A harm become a public harm when the conduct, in addition to harming the individual victim, harms or concerns the community as a whole. A public harm is viewed as a 'social and moral wrong that the community should regard as a wrong that ought to be prosecuted through public channels of prosecution and trial' (at 30). For more on the harm principle see J Herring *Great Debates in Criminal Law* 3ed (2015) 8-12. The arguments presented here are not being used to justify the criminalisation of involuntary sterilisations since this has already taken place, see section 3 of the article below. Instead, these arguments serve to justify the demand for increased state action in relation to involuntary sterilisations.

<sup>34</sup> See s 7(1) of the Constitution of the Republic of South Africa, 1996.

within the broader discussions about violence against women, an issue that the state is obligated to recognise and actively seek to address. Multiple international instruments are increasingly recognising that violence against women must be investigated and perpetrators prosecuted, amongst other required actions.<sup>35</sup>

Civil society has limited means and where it carries the burden of seeking redress, access to justice will be available to only a select few.<sup>36</sup> In the case of criminal prosecution, the state bears the cost of litigation and criminal prosecutions are not hampered by civil law's short prescription periods.<sup>37</sup> Further, civil actions, in the form of delictual claims, have limited reach. It is true that there are actions that can constitute both a crime and a delict, and involuntary sterilisations may be one of them,<sup>38</sup> but there are significant differences between the two. Aside from different burdens of proof, procedural aspects and sanctions, the most glaring difference is the fact that under delict, a finding of wrongdoing does not speak to a violation of broader public interests *per se*. Instead, it speaks to the violation of one individual's interests.<sup>39</sup> Remedying the violation of individual private interests does little for systematic and systemic human rights violations,<sup>40</sup> as is seen to occur in the context of involuntary sterilisations.

Consideration of the role of criminal law not only demonstrates the obligation of the state to act in cases of involuntary sterilisations but also forces one to question how criminal-law principles apply to the instances, which is something yet to be done in a South African context.

### **3 Crimes relevant to involuntary sterilisation**

Both the common and statutory law offer women avenues for criminal prosecution in cases where they were involuntarily sterilised. The common-law crime of assault is available to women who were sterilised prior to the enactment of the Sterilisation Act 44 of 1998, provided that the crime has not prescribed in terms of s 18 of the Criminal

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<sup>35</sup> For instance, see the 'Addis Ababa Declaration on Population and Development in Africa beyond 2014' (2013); the 'Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2003); 'International Conference on Population and Development' (1994); 'Declaration on the Elimination of Violence Against Women' (1993); and 'Convention on the Elimination of all Forms of Discrimination against Women' (1979) together with 'General Recommendations' 12 and 19.

<sup>36</sup> For instance, see Gonzalez-Flores *op cit* (n6) 8.

<sup>37</sup> See s 18 of the Criminal Procedure Act 51 of 1977.

<sup>38</sup> See *Christian Lawyers Association v Minister of Health* 2005 (1) SA 509 (T) at 515D.

<sup>39</sup> CR Snyman *Criminal Law* 5ed (2008) 5.

<sup>40</sup> J Burchell *Principles of Criminal Law* 4ed (2013) 204.

Procedure Act 51 of 1977. For those women who were sterilised after the enactment of the Sterilisation Act 44 of 1998, s 9 together with ss 2 and 4, and the common-law crime of assault are available, subject to the limitations of ss 18 and 336 of the Criminal Procedure Act 51 of 1977.<sup>41</sup> These two crimes will now be considered.

From a statutory perspective, s 9 of the Sterilisation Act 44 of 1998 provides that '[a]ny person who contravenes or fails to comply with the provisions of this Act is guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding five years'. Since involuntary sterilisation hinges on the allegation that consent is lacking, ss 2 and 4 are applicable. Section 2(2) provides that a person cannot be sterilised without his or her consent, provided he or she has the capacity to consent. Aside from capacity, s 4(a) specifically requires that consent must be informed, in so far as the procedure, its nature (reversible or irreversible), consequences and risks are clearly and adequately explained. Further, s 4(b) and (c) provides that a consent form must be signed and reaffirms a patient's right to withdraw consent at any time before commencement of the sterilisation procedure. Reading these provisions together, it is clear the Sterilisation Act 44 of 1998 is well equipped to address the issues of involuntary sterilisation in South Africa.

It is interesting to note that the wording of s 9 of the Sterilisation Act 44 of 1998 is not explicit in respect of which form of fault (intention or negligence) is required. However, there are presumptions that some degree of fault is required when interpreting statutory offences, and that the required form of fault is intention, unless there are express indications in the statute's language, context, scope or object that indicates to the contrary.<sup>42</sup> According to Fannin J in *S v Naidoo*,<sup>43</sup> words such as 'negligently', 'without due care' or words that may resemble these terms may point to the intention of the legislature to broaden the scope of criminal liability to negligent conduct. Further, when determining whether negligence will suffice, *S v Naidoo*<sup>44</sup> provides that 'to regard *culpa* as sufficient for criminal liability in

<sup>41</sup> Section 336 of the Criminal Procedure Act 51 of 1977 provides that:

'Where an act or omission ... is an offence against a statutory provision and the common law, the person guilty of such act or omission shall, unless the contrary intention appears, be liable to be prosecuted and punished ... under the statutory provision or the common law, but shall not be liable to more than one punishment for the act or omission constituting the offence.'

<sup>42</sup> Burchell op cit (n40) 388-390; G Kemp, S Walker, R Palmer, D Baqwa, C Gevers, B Leslie and A Steynberg *Criminal Law in South Africa* (2012) 233-239; *S v Arenstein* 1964 (1) SA 361 (A); *S v Naidoo* 1974 (4) SA 574 (N); and *S v Van Zyl* 2000 (1) SACR 259 (C).

<sup>43</sup> Supra (n42) at 575H-576A.

<sup>44</sup> Supra (n42) at 596C-D.

statutory offences, involves an extension of criminal liability and an infringement of the fundamental rule of our law that criminal statutes should be benevolently construed in favour of individual freedom'.

A reading of the Sterilisation Act 44 of 1998, in the light of guidance emanating from case law and academic commentary, suggests that s 9 requires a measure of fault, especially given the use of 'fails to comply' in s 9.<sup>45</sup> Also, that intention is the required degree of fault because there is no express indication that the legislature intended to broaden liability to include negligent non-compliance with the provisions of the Act.

A conviction under the Sterilisation Act 44 of 1998 can be avoided where the health care provider demonstrates that the consent provisions of the Act were complied with. He or she must demonstrate that consent was informed, freely and voluntarily provided by a competent patient, who also signed the required consent form. More on the issues of consent will be considered below.<sup>46</sup>

The additional crime of assault is also applicable to involuntary sterilisations. This common-law crime may be applicable to those involuntary sterilisations performed prior to the enactment of the Sterilisation Act 44 of 1998. It may also be applicable to involuntary sterilisations performed after the enactment of the Sterilisation Act 44 of 1998. Thus, a perpetrator may be charged with contravening the Sterilisation Act 44 of 1998 and assault, but may not be punished for both crimes.<sup>47</sup> However, it may be beneficial for the prosecutor to pursue a conviction under the Sterilisation Act 44 of 1998 because s 9 offers a longer period of imprisonment compared to that available for assault.<sup>48</sup>

Assault is defined as the unlawful and intentional application of force to the person of another or inspiring a belief that force will be immediately applied.<sup>49</sup> Any conduct applied to the person of another will constitute assault if it intentionally causes an impairment of a person's bodily integrity.<sup>50</sup> The common-law crime of assault does not have to result in actual harm; even a touch will suffice if that touch impairs the victim's bodily integrity.<sup>51</sup> Consequently, assault covers a

<sup>45</sup> See *S v Arenstein* supra (n42) at 365E.

<sup>46</sup> See section 4 of the article below.

<sup>47</sup> See ss 18 and 336 of the Criminal Procedure Act 51 of 1977. See also PM Bekker, T Geldenhuys, JJ Joubert, JP Swanepoel, SS Terblanche and SE van der Merwe *Criminal Procedure Handbook* 8ed (2007) 188.

<sup>48</sup> Perusal of case law indicates that a conviction for common assault may not result in such a lengthy sentence.

<sup>49</sup> Snyman op cit (n39) 455; Burchell op cit (n40) 577; and Kemp et al op cit (n42) 279.

<sup>50</sup> Snyman op cit (n39) 460 and Burchell op cit (n40) 582.

<sup>51</sup> Snyman op cit (n39) 457 and Burchell op cit (n40) 582.

wide range of conduct which does not necessarily have to be 'violent' in nature.<sup>52</sup> Assault can be committed through another,<sup>53</sup> or by an omission in the case where someone is under a legal duty to act and fails to do so.<sup>54</sup>

If the application of force can be justified, unlawfulness of the conduct is negated.<sup>55</sup> While there are many defences available,<sup>56</sup> the defence of consent is relevant to the context of sterilisation.<sup>57</sup> An assault will be lawful where the victim has consented to the harm.<sup>58</sup> However, there are limits to the defence of consent; these limits include:<sup>59</sup> the law must recognise consent as a possible defence, consent should be given voluntarily and be free from coercion, the person should provide informed consent and the person should have the capacity to consent.

Given that any intentional interference with the body of another without their consent constitutes the crime of assault, it can be concluded that sterilisation without consent can amount to an assault. A number of academics in the areas of South African criminal and medical law support the notion that medical treatment without consent constitutes assault.<sup>60</sup> However, it is interesting to note that there are no reported criminal-law cases which directly apply principles relevant to common-law assault to medical treatment without informed consent.<sup>61</sup> The case law that most academics use to support the conclusion that

<sup>52</sup> Snyman op cit (n39) 456; Burchell op cit (n40) 582; and P Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007) 502.

<sup>53</sup> *S v A* 1993 (1) SACR 600 (A) 602.

<sup>54</sup> *S v B* 1994 (2) SACR 237 (E) 239 and Kemp et al op cit (n42) 281.

<sup>55</sup> Snyman op cit (n39) 95 and Burchell op cit (n40) 205.

<sup>56</sup> See Snyman op cit (n39) 95-148 for a discussion of some of the possible grounds of justification.

<sup>57</sup> Given the fact that a sterilisation procedure will never constitute an emergency medical procedure, the defence of necessity will not be considered. See World Health Organization op cit (n1) 14, which provides that a sterilisation is not a matter of medical emergency because the procedure aims to prevent future pregnancies. Consequently, there is sufficient time to consult with a patient and obtain informed consent.

<sup>58</sup> This is determined with reference to public policy and the community's perception of justice; see Snyman op cit (n39) 125 and Kemp et al op cit (n42) 114.

<sup>59</sup> Snyman op cit (n39) 124-128 and Burchell op cit (n40) 205.

<sup>60</sup> FFW van Oosten *The Doctrine of Informed Consent* LLD (University of South Africa) (1989) 51; LC Coetzee and P Carstens 'Medical malpractice and compensation in South Africa' (2011) 86 *Chicago-Kent LR* 1263 at 1290; Kemp et al op cit (n42) 115; Burchell op cit (n40) 207 and 582; D McQuoid-Mason and M Daada *A-Z of Medical Law* (2011) 30 and Snyman op cit (n39) 129.

<sup>61</sup> In *S v Sikunyana* 1961 (3) SA 549 (E) at 551H, the court recognised that a 'medical practitioner who performs a dangerous operation with his patient's consent incurs no criminal responsibility if just cause for the operation exists, for the law does not regard his conduct as improper'. This is considered *obiter* because the facts before the court did not concern medical treatment without consent. The facts concerned the assault of a young woman with the aim to expel evil spirits.

treatment without consent constitutes the crime of assault originates from mainly civil-law actions for damages in the context of medical treatment without informed consent.<sup>62</sup> Though helpful, this case law may not necessarily suffice as adequate authority in a criminal-law context.<sup>63</sup>

This is not to say that medical treatment without consent cannot constitute criminal assault. Theoretically it clearly can, provided that the definitional requirements for assault have been met. However, citing case law relevant to delict hampers a detailed probe of criminal-law principles and their applicability to the complex area of involuntary medical treatment of competent individuals and involuntary sterilisation more specifically.

Demonstrating that certain criminal-law provisions are relevant to involuntary sterilisation is not enough. This article will go further. It will demonstrate that the reproductive health care environment is a complex maze of relationships and this impacts on consent-acquiring practices and the application of criminal-law principles. Further, it explores how existing case law and criminal-law principles can be used to secure criminal liability for involuntary sterilisation within the different relationships.

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<sup>62</sup> The following cases are cited as authority by the various authors: *Lampert v Hefer* 1955 (2) SA 507 (A); *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T); *Castell v De Greef* 1994 (4) SA 408 (C); *Broude v McIntosh* 1998 (3) SA 60 (SCA); *Louwrens v Oldwage* 2006 (2) SA 161 (SCA); *Burger v Administrateur, Kaap* 1990 (1) SA 483 (C); *Richter v Estate Hammann* 1976 (3) SA 226 (C); *Stoffberg v Elliott* 1923 CPD 148; and *McDonald v Wroe* [2006] 3 All SA 565 (C). Van Oosten op cit (n60) does not rely on any civil-law cases; he specifically recognises that there are no criminal law cases to support this position but refers to *S v Sikunyana* supra (n61) as indirect authority. Coetzee and Carstens op cit (n60) 1290 also refer to *S v Sikunyana* supra (n61) in addition to *S v Binta* 1993 (2) SACR 553 (C) and *S v Kiti* 1994 (1) SACR 14 (E). However, neither of these judgments are concerned with the assault of a patient but with obstructing the course of justice.

<sup>63</sup> While the courts have indeed referred to 'assault' in the context of medical treatment without informed consent, it has only been in relation to civil assault. A finding of a civil wrong does not in itself automatically render the same behaviour criminally wrong. More is required, and to date, this has not been explicitly tested in or determined by a criminal court. Going further, the judicial approach of referring to conduct as an assault in a civil context has its own flaws because, at times, the term has been used in relation to negligent conduct and not intentional conduct. See JC van der Walt and JR Midgley *Principles of Delict* 3ed (2005) 111; *Broude v McIntosh* supra (n62) at 67F-68F and *Pandie v Isaacs* supra (n10) at para [34]. Thus, these judgments cannot be cited as authority for establishing the crime of assault which requires intentional conduct.

#### 4 Complexities of the reproductive health care environment and consent

At first glance, intentionally performing a sterilisation without a patient's informed consent can constitute the crime of assault and/or be a crime in terms of the Sterilisation Act 44 of 1998. However, there are consent-acquiring issues that arise in the context of sterilisations which complicate the application of these principles to this specific area. To date, these have not been identified or meaningfully explored in relation to sterilisations in the context of criminal law, and this results in a gap in available literature which may hamper successful prosecution of various offences.

Both the common law and s 4 of the Sterilisation Act 44 of 1998 require consent to be voluntary and informed. Section 4 of the Sterilisation Act 44 of 1998 goes further and requires that consent be in writing and there is an obligation to advise a patient that consent can be withdrawn any time before commencement of the procedure. Neither the Act nor the common law explicitly indicate who is responsible for obtaining consent (nurse or doctor), who should ensure consent has been properly obtained, under what circumstances consent can be given (in relation to capacity), or exactly when, during the reproductive health care process, consent should be given. Essentially, it is not clear who should ensure that the patient is fully informed and that medical treatment is properly aligned to the patient's expressed position. There is no explicit recognition of the various relationships implicated in a sterilisation procedure (patient/doctor and patient/nurse), how the different relationships impact one another, and the associated responsibilities as a result of the existing relationships.

These gaps render the law susceptible to manipulation or flawed application, and both instances increase the vulnerability of women who access reproductive health care services in South Africa. Also, in cases where legal obligations are not met and human rights have been violated, the law may not be relied on because the gaps create uncertainty surrounding the applicability of certain legal principles to particular role players and areas of medical treatment. These are valid concerns especially when one considers the involuntary sterilisation of Ms Isaacs in *Isaacs v Pandie*<sup>64</sup> and *Pandie v Isaacs*,<sup>65</sup> and the consent-acquiring practices in relation to sterilisation of women living with HIV.

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<sup>64</sup> Supra (n10).

<sup>65</sup> Supra (n10).

#### 4.1 Refusal to consent

As mentioned above, *Isaacs v Pandie*<sup>66</sup> and *Pandie v Isaacs*<sup>67</sup> are the only available case law on involuntary sterilisation in South Africa. Even though these cases concern a civil-law action for damages, each highlights the flaws inherent in the application of consent requirements for sterilisation procedures and thus emphasises how difficult it might be to secure criminal liability.

Ms Isaacs alleged that, during antenatal consultations with Dr Pandie, she repeatedly refused consent to sterilisation, but according to Dr Pandie, Ms Isaacs had allegedly consented to sterilisation during her last antenatal consultation, being the day before admission for the caesarean-section delivery of her child.<sup>68</sup> Despite this factual dispute, Ms Isaacs did refuse to sign the sterilisation consent form when being admitted into hospital for the caesarean-section delivery.<sup>69</sup> Also, while in theatre, she repeatedly said that she did not want to be sterilised.<sup>70</sup> Nevertheless, Dr Pandie sterilised her after an assisting scrub sister confirmed that he should.<sup>71</sup> Dr Pandie did not consult Ms Isaacs' consent form and he did not consult Ms Isaacs immediately prior to performing the caesarean-section delivery.

On the issue of consent, Dr Pandie admitted that he does not personally take written consent from his patients and that he does not check whether the consent forms are signed by patients.<sup>72</sup> According to him, it is the scrub sister who must check whether patients have signed consent forms when they are received into theatre.<sup>73</sup> He further provided that he did not consider it necessary to ask Ms Isaacs whether she still wanted to be sterilised because, '(a) he had discussed the issue with the Plaintiff the previous day, and (b) the Plaintiff would not have been in the position to give him a proper answer given the euphoria of her baby being born' and that he 'never asks his patients about [the] operation that he was doing on them at that stage'.<sup>74</sup> However, in a written letter to Ms Isaacs' attorneys which the court considered, Dr Pandie stated that 'the Plaintiff and her husband had an opportunity in the labour ward and theatre to inform the staff and himself about the Plaintiff's change of plan'.<sup>75</sup>

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<sup>66</sup> *Supra* (n10).

<sup>67</sup> *Supra* (n10).

<sup>68</sup> *Isaacs v Pandie supra* (n10) at paras [6] and [34].

<sup>69</sup> *Isaacs v Pandie supra* (n10) at para [7].

<sup>70</sup> *Isaacs v Pandie supra* (n10) at para [8].

<sup>71</sup> *Isaacs v Pandie supra* (n10) at para [9].

<sup>72</sup> *Isaacs v Pandie supra* (n10) at para [36].

<sup>73</sup> *Isaacs v Pandie supra* (n10) at para [37].

<sup>74</sup> *Isaacs v Pandie supra* (n10) at paras [37] and [42] respectively.

<sup>75</sup> *Isaacs v Pandie supra* (n10) at para [42].

The sister, who was the shift leader at the time of Ms Isaacs' involuntary sterilisation, confirmed that nurses fill in the consent forms and it was her responsibility to collect and check the forms.<sup>76</sup> She indicated that she made Ms Isaacs aware of Ms Isaacs' responsibility for conveying her change of mind to Dr Pandie, twice.<sup>77</sup> Ms Isaacs' two expert witnesses both agreed that the doctor performing the surgery must personally check the consent form, as should the theatre staff.<sup>78</sup> Personally checking the consent forms was viewed as essential in the case of sterilisations because sterilisations end the reproductive lives of patients.<sup>79</sup> This approach is in line with informed consent regulations and guidelines issued by the Health Professions Council of South Africa.<sup>80</sup>

In addition to several findings, the high court found that Dr Pandie had assaulted Ms Isaacs because consent was lacking and that he was negligent for not consulting Ms Isaacs' consent form.<sup>81</sup> However, on appeal to the full bench, the judgment was overturned.<sup>82</sup>

The full bench found that health care guidelines are not law and merely assist with determining the standards to be reasonably expected of health care providers. It found that Dr Pandie 'performed the sterilisation in the *bona fide* belief that the plaintiff had consented, and that in so doing he acted in accordance with prevailing practice in his profession and was not negligent.'<sup>83</sup> Instead, the court saw the evidence as suggesting that the hospital staff were negligent, but since that was not pleaded, it was not decided on.<sup>84</sup> The court accepted Dr Pandie's expert witness, a fellow surgeon, who stated that he 'did not know of any surgeons who themselves checked the written consent forms'.<sup>85</sup>

The court did not make a finding regarding whether Ms Isaacs was under an obligation to inform Dr Pandie that she had changed her mind.<sup>86</sup> This approach appears to place the responsibility squarely on the shoulders of nurses because the patient is not under an obligation to speak to the doctor prior to surgery and the doctor is not under an

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<sup>76</sup> *Isaacs v Pandie* supra (n10) at para [49].

<sup>77</sup> *Ibid.*

<sup>78</sup> *Isaacs v Pandie* supra (n10) at paras [31] and [51] respectively.

<sup>79</sup> *Isaacs v Pandie* supra (n10) at para [31].

<sup>80</sup> *Ibid.* See the Health Professions Council of South Africa 'Guidelines for good practice in the health care professions: Seeking patients informed consent: Ethical considerations' (2008) at 6, para 5.2.

<sup>81</sup> *Isaacs v Pandie* supra (n10) at paras [66] and [72].

<sup>82</sup> *Pandie v Isaacs* supra (n10).

<sup>83</sup> *Pandie v Isaacs* supra (n10) at para [46].

<sup>84</sup> *Ibid.*

<sup>85</sup> *Pandie v Isaacs* supra (n10) at para [76].

<sup>86</sup> *Pandie v Isaacs* supra (n10) at para [53].

obligation to speak to the patient prior to surgery. This responsibility stands even though nurses do not perform the sterilisation procedure. This approach to consent blurs the boundaries of the law. Ms Isaacs clearly refused to sign the consent form and she repeatedly expressed her position while waiting for Dr Pandie to arrive in theatre.<sup>87</sup> Given that Dr Pandie performed the procedure, and in the light of his concession that he does not question patients during procedures, his personal examination of the consent form is all the more significant. In any case, the court accepted that it was the responsibility of the hospital staff to inform Dr Pandie that Ms Isaacs had changed her mind.<sup>88</sup>

These decisions demonstrate that consent requirements, while relatively clear-cut in principle, can be complicated by the maze of relationships and shifting responsibilities at play in relation to sterilisations. These fluid and seemingly indeterminable responsibilities can serve as a serious impediment to the application of s 9 of the Sterilisation Act 44 of 1998 and criminal-law principles of assault to involuntary sterilisations.

Focusing on the doctor/patient relationship and using Dr Pandie's experience as an example, it is necessary to determine whether a doctor can be held liable for assault or contravening the Sterilisation Act 44 of 1998 on the basis of involuntary sterilisation. Clearly, the attending health care provider contravenes the Act or commits assault when he or she intentionally sterilises a patient knowing that consent is lacking. Still, this position becomes problematic when it is alleged by the attending health care provider, that as a result of a previous conversation, he or she *bona fide* believed that the patient had provided informed, voluntary and written consent and therefore went ahead with the sterilisation.

In this instance, a *bona fide* belief in the existence of a ground of justification (namely, consent) does not render the conduct lawful.<sup>89</sup> Sterilisations under those circumstances remain unlawful. However, according to Snyman, a mistake relating to unlawfulness may exclude intention.<sup>90</sup> When determining whether a mistake excludes intention, the individual characteristics of the wrongdoer must be considered, and the genuineness and reasonableness of the mistake are factors which indicate that there is a mistake.<sup>91</sup>

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<sup>87</sup> *Isaacs v Pandie* supra (n10) at paras [7]-[8].

<sup>88</sup> *Pandie v Isaacs* supra (n10) at para [84].

<sup>89</sup> Snyman op cit (n39) 102.

<sup>90</sup> Snyman op cit (n39) 103.

<sup>91</sup> Snyman op cit (n39) 192. See Burchell op cit (n40) 386 for a contrary view.

*S v Reabow*<sup>92</sup> is helpful regarding the application of these principles. Mr Reabow (an off-duty police officer) mistakenly identified a running pedestrian for a bag-snatcher and placed his baton in the way of the pedestrian in order to stop the pedestrian from running away.<sup>93</sup> The baton struck the pedestrian in the face and caused serious injuries. Mr Reabow was convicted in the magistrates' court on a charge of assault with intent to do serious bodily harm. On appeal, it was argued that Mr Reabow lacked the necessary intention because he believed his conduct was authorised by s 49 of the Criminal Procedure Act 51 of 1977<sup>94</sup> and therefore, he was acting 'without knowledge of unlawfulness of his conduct because he believed that he was entitled to use force in the circumstances'.<sup>95</sup>

The court recognised that in order for this argument to succeed, the mistake must be material and genuine.<sup>96</sup> Accepting the mistake as material, the court questioned whether the mistake was genuine.<sup>97</sup> It considered the accused's personal characteristics such as the fact that he had extensive experience as a police officer and that he held a senior position of leadership and responsibility.<sup>98</sup> On this basis, the court found that he 'must be taken to know the law that authorises him to use the force in the execution of his duties. There can be no other reasonable inference but this.'<sup>99</sup> Further,

'in these circumstances, a belief on the part of the appellant that he was entitled to use force to stop the complainant is so unreasonable that, when regarded in the light of his senior position and years of experience, the inference is overwhelming – and inescapable, in my view – that the appellant did not hold a genuine, honest or *bona fide* belief that his actions were authorised by s 49(1) of the [Criminal Procedure] Act [51 of 1977].'<sup>100</sup>

Consequently, his argument that he lacked intention failed.<sup>101</sup>

Applying these principles to Dr Pandie's arguments in relation to Ms Isaacs' involuntary sterilisation, it can be accepted that as an obstetrician, Dr Pandie has sufficient experience and is knowledgeable of the laws regulating his practice, particularly the well-established

<sup>92</sup> 2007 (2) SACR 292 (E).

<sup>93</sup> *S v Reabow* supra (n92) at para [2].

<sup>94</sup> This provision regulates that use of force in effecting arrest.

<sup>95</sup> *S v Reabow* supra (n92) at para [20].

<sup>96</sup> *Ibid.*

<sup>97</sup> *S v Reabow* supra (n92) at paras [20]-[21]. A material mistake is a mistake regarding the act, definitional elements of a crime or unlawfulness. See Snyman op cit (n39) 192.

<sup>98</sup> *S v Reabow* supra (n92) at paras [22].

<sup>99</sup> *S v Reabow* supra (n92) at para [22].

<sup>100</sup> *S v Reabow* supra (n92) at para [24].

<sup>101</sup> *Ibid.*

consent requirements in terms of the common law and the Sterilisation Act 44 of 1998. Part of these consent requirements is the fact that a patient can withdraw his or her consent at any time prior to the commencement of the relevant procedure;<sup>102</sup> thus, consent provided the day before a procedure does not guarantee consent the following day when the sterilisation is expected to take place. It must be known that patients change their minds and are free to do so. Given that it is the obstetrician performing the procedure, it is expected of him or her to make an effort to bring his or her conduct within the parameters of the law governing his or her practice, even if that requires personally assessing the signed consent form or having a brief consultation prior to commencement of the procedure.<sup>103</sup> Thus, if no effort is made to engage the patient, the obstetrician's subjective belief that consent was provided may be so unreasonable that his or her mistake will not be *bona fide* or fails to do so.

## 4.2 Signed consent forms

Considering the involuntary sterilisation of women living with HIV brings focus to the nurse/patient relationship. The nurse/patient relationship must be considered because it is widely accepted that nursing staff are responsible for acquiring written consent upon admission to hospital. Strode, Mthembu and Essack's report demonstrates a clear measure of intentional deception and underhandedness of some nursing staff<sup>104</sup> when acquiring patients' signed consent for sterilisation.<sup>105</sup> For instance, Strode, Mthembu and Essack reported that women were sterilised while seeking other reproductive health care services, indicating that sterilisation was not the reason for accessing health care services.<sup>106</sup> Consent forms were provided without any explanation regarding the content of the consent form or the consequences of signing it.<sup>107</sup> Women were refused access to other necessary reproductive health care services if they failed to

<sup>102</sup> See s 4(b) of the Sterilisation Act 44 of 1998 and Snyman op cit (n39) 128.

<sup>103</sup> According to Shokrollahi, a signed consent form merely holds an evidentiary value and is not itself consent; see K Shokrollahi 'Request for treatment: The evolution of consent' (2010) 92 *Annals Royal College of Surgeons of England* 93 at 94. However, a signed consent form might be helpful when a patient is anaesthetised and unable to articulate his or her position regarding a surgical procedure.

<sup>104</sup> Strode, Mthembu and Essack's study (op cit (n11)) found that nurses and doctors were implicated in obtaining signed consent. This article will first consider the criminal liability of nurses and then doctors in relation to defective signed consent forms.

<sup>105</sup> See generally Strode, Mthembu and Essack op cit (n11).

<sup>106</sup> Strode, Mthembu and Essack op cit (n11) 6.

<sup>107</sup> Strode, Mthembu and Essack op cit (n11) 63-64.

sign the consent form, or they were given consent forms very late in the labour process or while being wheeled into theatre for purposes of caesarean-section delivery.<sup>108</sup>

At the centre of the controversy are nurses and their conduct prior to surgery, but nurses do not perform the sterilisation procedure, doctors do.<sup>109</sup> This might give the impression that if doctors are *bona fide* sterilising women on the basis of signed consent forms, then no one can be charged for contravening the Sterilisation Act 44 of 1998 or assaulting the women who were involuntary sterilised.<sup>110</sup> This must be explored because, in some of the described instances, it is quite clear that nurses know that valid consent is lacking (due to their own conduct when obtaining consent) and nevertheless allow women to be sterilised.<sup>111</sup>

It is submitted that these facts trigger assault by omission and the following discussion will justify this position. *S v B*<sup>112</sup> serves as an example of assault by omission. Here, the mother of a two-year-old child allowed another person to systematically assault her child over a two-month period.<sup>113</sup> The assaults were severe and resulted in the two-year-old's death.<sup>114</sup> Both the third party and the two-year-old's mother were charged with assault with intent to do grievous bodily harm and murder.<sup>115</sup> On the issue of assault with intent to do grievous bodily harm, the Eastern Cape division found that where the parent

'was aware of the assaults on the deceased and allowed them to happen and had foreseen the possibility that accused No 2 could seriously assault the deceased, in abandoning her parental duty of protection of the child, was guilty of assault with the intent to do serious bodily harm'.<sup>116</sup>

This finding suggests that in order for a nurse to be held criminally liable for assault in the case of involuntary sterilisation, he or she must be under a legal duty to act, namely, to prevent sterilisation under

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<sup>108</sup> Strode, Mthembu and Essack op cit (n11) 65.

<sup>109</sup> Ms Isaacs experienced something similar; see *Isaacs v Pandie* supra (n10) and *Pandie v Isaacs* supra (n10).

<sup>110</sup> Personal communication with Jody Lee Fredericks, 30 July 2015. Ms Fredericks is an attorney at the Women's Legal Centre and serves as a legal representative for some of the women who participated in Strode, Mthembu and Essack's explorative study (op cit (n11)).

<sup>111</sup> For purposes of the current assessment of nurses' criminal liability, it is presumed that doctors are *bona fide* performing sterilisations on the basis of the signed consent forms.

<sup>112</sup> Supra (n54). Also see Snyman op cit (n39) 456-458.

<sup>113</sup> *S v B* supra (n54) at 238G-H.

<sup>114</sup> *S v B* supra (n54) at 238H.

<sup>115</sup> Ibid.

<sup>116</sup> *S v B* supra (n54) at 239A.

circumstances where it is personally known to the nurse that consent is lacking, and failed to do so.

It is submitted that, in respect of the common-law crime of assault, such a legal duty does exist. A legal duty to act has been recognised in a number of instances such as when a person has accepted responsibility for the control of a dangerous object, when a person is part of a protective relationship, when a person is the incumbent of a particular office or when a person has acted previously and he or she later failed to prevent harm in relation to the previous commission.<sup>117</sup> Snyman specifically identifies medical professionals as being under a duty to act as a result of holding the office of a medical professional.<sup>118</sup>

In fact, if one considers the patient/nurse relationship in the context of consent for sterilisation, there are further grounds which justify recognising a legal duty to prevent a sterilisation when the consent provided is known to be defective. First, the consent is defective as a result of prior conduct by nursing staff in so far as they secured a signed consent form through dishonest conduct. Second, nurses stand in a relationship of trust with patients and it can be argued that they are in a protective relationship with their patients. This position is supported by *R v Chenjere*,<sup>119</sup> where the court found that a legal duty to act arises 'where the potential victim is helpless through infancy, senility or illness and the potential killer stands, either naturally or through a deliberate acceptance of responsibility, in a protective relationship to the victim'. The court further emphasised that 'protective relationship' should not be interpreted restrictively and should be determined with reference to the facts.<sup>120</sup> Ultimately, the presence of these grounds provide a strong indication that the legal convictions of the community demand that nurses should act to prevent sterilisations when they know consent forms are defective, particularly when it is their conduct that renders signed consent forms defective. Nurses must know that obstetricians will sterilise women on the basis of signed consent forms and this will amount to a violation of women's bodily integrity because valid consent is lacking.

While the Sterilisation Act 44 of 1998 does not have an express provision similar to assault by omission, it may still be helpful in these circumstances. Section 9 of the Act provides that 'any person who contravenes or fails to comply with the provisions of this Act is guilty of an offence'. Section 4 specifically requires consent to be given

<sup>117</sup> See Snyman op cit (n39) 59-60.

<sup>118</sup> Snyman op cit (n39) 60. Although there is no case law to support this position in criminal law, it is asserted that Snyman's position is supported by the South African Nursing Council *Code of Ethics for Nursing Practitioners in South Africa* (2014) at 3.

<sup>119</sup> 1960 (1) SA 473 (FC) at 482B-C.

<sup>120</sup> *R v Chenjere* supra (n119) 482D.

freely and that the patient be informed of the consequences, risks and nature of the sterilisation procedure. Thus, 'any one' is wide enough to include nursing staff who are charged with obtaining consent and fail to meet s 4 obligations. While the nursing staff may not perform the sterilisation procedure, they may still face criminal liability under the Act because of the failure to obtain 'consent' as defined in terms of the Sterilisation Act 44 of 1998.

Accepting that nursing staff can face criminal charges for criminal assault or for contravening s 4 of the Sterilisation Act 44 of 1998, it is necessary to return focus to the doctor/patient relationship, and consider whether a doctor can be criminally liable for performing sterilisations on the basis of defective but signed consent forms. A signed consent form can be considered defective for a number of reasons, one being the fact that consent was not voluntary.

In Ms Isaacs' case,<sup>121</sup> there was no signed consent form and it was established that Dr Pandie could face criminal prosecution if it could be shown his mistaken belief that consent was given was not genuine or *bona fide*. However, in Strode, Mthembu and Essack's study,<sup>122</sup> there were signed consent forms which were obtained by nursing staff and it can be presumed that doctors were sterilising women in terms of these forms. These circumstances draw attention to the legal significance of signed consent forms and raise the question: in cases where doctors are not participating in obtaining written consent, is a signed consent form sufficient enough to render a mistake concerning unlawfulness *bona fide* or genuine?

It is proposed that doctors can be held criminally liable for assault or contravention of the Sterilisation Act 44 of 1998 in these circumstances because a signed consent form is not informed consent; more is needed. According to Van Oosten,<sup>123</sup> signed consent forms cannot serve as a substitute for disclosure conversations, being those conversations in which all the necessary information is provided and explained to patients concerning a particular course of treatment.<sup>124</sup> On that basis, he suggests that signed consent forms should be afforded some evidential value 'but should not be considered as conclusive evidence that the requisite disclosure in fact occurred'.<sup>125</sup> This position is clearly articulated in s 4 of the Sterilisation Act 44 of 1998. Section 4 provides that in order for consent to be valid, the patient must sign the

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<sup>121</sup> *Isaacs v Pandie* supra (n10).

<sup>122</sup> Op cit (n11).

<sup>123</sup> As cited by Coetzee and Carstens op cit (n60) 1291.

<sup>124</sup> See SA Strauss *Doctor, Patient and the Law* 3ed (1991) 12-13 and A Meisel and M Kuczewski 'Legal and ethical myths about informed consent' (1996) 156 *Archives of Internal Medicine* 2521 at 2522-2523.

<sup>125</sup> Coetzee and Carstens op cit (n60) 1291.

prescribed consent form and this requirement is in addition to being 'given a clear and adequate description' of the sterilisation procedure, its risks, consequences and nature.

*Government of the Republic of Namibia v LM*<sup>126</sup> mirrors Van Oosten's position on signed consent forms. In this case three women living with HIV were sterilised after caesarean-section deliveries, but neither of them were admitted for purposes of sterilisation.<sup>127</sup> Although each woman signed a consent form, the forms were signed while they were in active labour or after having faced prolonged labour, and allegedly without being given a chance to read the forms or have the forms explained.<sup>128</sup> Also, the implicated hospitals had no record of whether the women had been given the necessary information so as to render their consent informed and voluntary.<sup>129</sup> The women instituted civil action against the Namibian state, arguing that their sterilisations were unlawful because the procedures were performed without informed consent.

The Supreme Court of Namibia found that signed consent forms are insufficient evidence of informed consent:

'Whether or not the respondents gave their informed consent to the sterilisation procedures is largely a factual question. For that reason, it requires a consideration of the circumstances in which the respondents allegedly gave their consent.'<sup>130</sup>

The court considered the circumstances and recognised that the women did not go to hospital for purposes of sterilisation but delivery of their babies that signed consent was obtained while the women were busy labouring or when being taken to theatre; and that there was no documentation of the process of obtaining informed consent. On that basis, it found that, despite the existence of signed consent forms, the women had not given their informed consent.<sup>131</sup> Relying on South African case law,<sup>132</sup> the court recognised that labour was an inappropriate time to obtain informed consent for sterilisations because the pain of labour and associated complications negatively impact women's capacity to consent.<sup>133</sup> It found:<sup>134</sup>

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<sup>126</sup> *Supra* (n10).

<sup>127</sup> *Government of the Republic of Namibia v LM supra* (n10) at para [86].

<sup>128</sup> *Government of the Republic of Namibia v LM supra* (n10) at paras [9], [15], [36] and [90].

<sup>129</sup> *Government of the Republic of Namibia v LM supra* (n10) at para [100].

<sup>130</sup> *Government of the Republic of Namibia v LM supra* (n10) at para [4].

<sup>131</sup> *Government of the Republic of Namibia v LM supra* (n10) at para [108].

<sup>132</sup> *Christian Lawyers Association v Minister of Health supra* (n38) and *Castell v De Greef supra* (n62).

<sup>133</sup> *Government of the Republic of Namibia v LM supra* (n10) at para [108].

<sup>134</sup> *Ibid.*

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

An interesting facet of this case concerns the fact that the court accepted expert evidence which confirms that it is the duty of the treating doctor to explain procedures and confirm whether patients still want to be sterilised.<sup>135</sup> This may prove helpful for future prosecutions in South Africa because both the common law and the Sterilisation Act 44 of 1998 are silent on this issue.<sup>136</sup> To add further support for adopting this approach in South Africa, the Health Professions Council of South Africa confirms, in its guidelines on obtaining informed consent, that it is the responsibility of the health care practitioner who provides treatment to obtain informed consent, but that this responsibility can be delegated to suitably qualified persons.<sup>137</sup> In cases where delegation has occurred, the 'health care practitioner will remain responsible for ensuring that, before he or she starts any treatment, the patient has been given sufficient time and information to make an informed decision, and has given consent'.<sup>138</sup>

While this case concerns a civil claim against the Namibian state for sterilisations performed without informed consent, it is significant for the purposes of this article for three reasons. First, it confirms that a signed consent form, on its own, is insufficient evidence of informed consent. If a signed consent form fails to meet the civil-law burden of proof, it is likely to be insufficient to prove the presence of informed consent beyond a reasonable doubt for purposes of avoiding criminal liability. Second, if a signed consent form is not sufficient evidence of informed consent, in a practical setting, doctors should not blindly rely on the forms as indicators of informed consent to a procedure. Third, and building on from the second point, the highest court in Namibia supports the notion that doctors are under a duty to ensure that the patient has provided informed consent prior to commencement

<sup>135</sup> *Government of the Republic of Namibia v LM* supra (n10) at paras [49] and [52].

<sup>136</sup> In terms of s 39(1) of the Constitution of the Republic of South Africa, 1996, foreign law may be considered when interpreting the Bill of Rights.

<sup>137</sup> Health Professions Council of South Africa op cit (n80).

<sup>138</sup> *Ibid.*

of the sterilisation procedure. This provides a strong argument that the defence of *bona fide* or genuine mistake regarding the presence of consent will not be available to a doctor who fails to act on this responsibility and sterilises a patient merely on the basis of a signed consent form.<sup>139</sup>

In cases when the doctor deceitfully obtains signed consent, the signed consent form will not indemnify him or her from criminal liability in terms of the statute or common law.

### 4.3 Degrees of coercion

Strode, Mthembu and Essack's report demonstrates that different degrees of coercion were used in order to get women to consent to sterilisations and the authors state that 'it is unclear whether a court would perceive all reported levels of coercion, particularly subtle pressure, as having undermined and vitiated a woman's ability to make a voluntary decision'.<sup>140</sup> The authors identify the following as subtle factors which influenced women to consent to sterilisation: fear of health care providers, deference to health care workers because they are perceived to know better, perceptions of being powerless to control decision-making and feelings of disempowerment because of how health care providers engage with patients.<sup>141</sup>

These findings raise the question: presuming that capacity to consent is present, what degree of coercion is required in order for consent to be lacking, thus resulting in the assault of the patient or a contravention of the Sterilisation Act 44 of 1998? There is no guiding case law available on voluntary consent in relation to medical treatment. According to Snyman, coercion removes the voluntariness of consent, and without consent being provided voluntarily, there is no valid consent.<sup>142</sup> Snyman does not qualify this position in relation to particular degrees of coercion. Section 4 of the Sterilisation Act 44 of 1998 provides that consent must be given 'voluntarily without any inducement'. The Act does not define or qualify voluntary consent or inducement. It is suggested that subtle forms of coercion, particularly coercion emanating from reproductive health care providers within the context of reported sterilisations, removes the voluntariness of

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<sup>139</sup> The arguments presented in relation to *S v Reabow* supra (n92) support this conclusion.

<sup>140</sup> Op cit (n11) 66.

<sup>141</sup> Strode, Mthembu and Essack op cit (n11) 65.

<sup>142</sup> Op cit (n39) 126.

consent.<sup>143</sup> At this point it is necessary to consider why even these subtle forms of coercion negate the voluntariness of consent in the context of sterilisations.

The relationship between patients and health care providers (nurses and doctors) can be characterised as being hierarchical and authoritarian.<sup>144</sup> Castro and Erviti argue that there is an ‘imbalance of power within the physician-patient relationship, in which one actor is invested with power/knowledge and the other is “only a patient”.’<sup>145</sup> Doctors’ and nurses’ position of power and superior knowledge is further entrenched and bolstered when the patients being treated are indigent, have little education, cannot speak the language being used by health care providers or are marginalised individuals as a result of their gender, socio-economic and health status.<sup>146</sup> According to Castro and Erviti, this hierarchical relationship ‘is even greater during gynaecological or obstetrical procedures because of a woman’s physical and emotional vulnerability during pregnancy and labor.’<sup>147</sup> Furthermore, the position of authority over reproductive health care patients has been naturalised<sup>148</sup> through health professions’ training and practice and broader societal trends where women are viewed as having lower social status and are seen as ‘needing discipline and control for their own good’.<sup>149</sup>

Castro and Erviti demonstrate that the position of power and authority that vests in health care providers can create an environment that may enable the violation of women’s rights in relation to consent.<sup>150</sup> Through a study of 200 testimonies provided by women who had

<sup>143</sup> It is noted that the voluntariness of consent can be influenced by a number of factors which fall beyond the health care environment; these include developmental factors, illness-related considerations, psychological issues, cultural and religious values and external pressures. See LW Roberts ‘Informed consent and capacity of voluntarism’ (2002) 159 *Am J Psychiatry* 705. However, this article focuses specifically on the patient/health care provider relationship and voluntary consent.

<sup>144</sup> See generally R Castro and J Erviti ‘Violations of reproductive rights during hospital births in Mexico’ (2003) 7 *Health and Human Rights* 91; AA Veleza and TE Gerardt ‘About humanly giving birth: The insertion of the nursing in the humanization of birth movement in Brazil’ (2014) 1 *J Nursing and Socioenvironmental Health* 47; AFPL D’Oliveria, SG Diniz and LB Schraiber ‘Violence against women in health-care institutions: An emerging problem’ (2002) 359 *The Lancet* 1681; and R Jewkes and L Penn-Kekana ‘Mistreatment of women in childbirth: Time for action on this important dimension of violence against women’ (2015) 12 *PLOS Medicine* 1.

<sup>145</sup> Castro and Erviti op cit (n144) 94.

<sup>146</sup> See generally R Jewkes, N Abrahams and Z Mvo ‘Why do nurses abuse patients? Reflections from South African obstetric services’ (1998) 47 *Social Science & Medicine* 1781.

<sup>147</sup> Castro and Erviti op cit (n144) 94.

<sup>148</sup> Castro and Erviti op cit (n144) 97.

<sup>149</sup> D’Oliveria, Diniz and Schraiber op cit (n144) 1681.

<sup>150</sup> Castro and Erviti op cit (n144) 98.

suffered mistreatment while giving birth in Mexico, the authors reveal that health care providers use their position of power to control or intimidate women, promote conformity and obedience, discount women's opinions and knowledge and minimise women's roles to supportive roles instead of central ones. Research suggests this is a global issue.<sup>151</sup> In a South African context, Chadwick, Cooper and Harries demonstrate that these patient/provider relationships heighten feelings of inadequacy, distress, powerlessness, lack of control, anxiety and fear.<sup>152</sup>

Overt acts of coercion are not necessary when women are forced into the 'naturalised' position of subordination and powerlessness within the reproductive health care sector; acquiring consent in these circumstances is relatively easy.<sup>153</sup> Women may merely submit to treatment that they do not necessarily want, and submission does not constitute valid consent.<sup>154</sup> There is clearly an abuse of authority which excludes consent as a ground of justification; *S v S*<sup>155</sup> supports this position.

In *S v S*,<sup>156</sup> a policeman, after arresting a woman, ordered her to lie down in the car he was driving and he proceeded to have intercourse with her.<sup>157</sup> She said that she did not desire to have intercourse and even though the policeman did not use force against her, she felt

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<sup>151</sup> Castro and Erviti op cit (n144) 98-103.

<sup>152</sup> RJ Chadwick, D Cooper and J Harries 'Narratives of distress about birth in South African public maternity settings: A qualitative study' (2014) 30 *Midwifery* 862 at 886-887.

<sup>153</sup> Jewkes and Penn-Kekana op cit (n144) 1 state that women have little choice but to consent and give into the power of health care providers. This is not to say that voluntary consent is impossible in the context of hierarchical relationships; there can be positive hierarchical relationships which can facilitate upliftment. There are a number of ways to overcome the negative consequences of being in these relationships. J Flanigan 'Obstetric autonomy and informed consent' (2016) 19 *Ethical Theory and Moral Practice* 225 at 231 suggests treating and respecting pregnant and birthing women as competent agents and shifting the power imbalance by fully informing them about available treatment options. According to Roberts op cit (n138) 710, voluntary consent is a process which requires 'listening, sensing, clarifying, making the implicit explicit, and genuinely attending to the person', respecting patients' experiences and values. It also requires a willingness to recognise and evaluate personal bias and the effects of different contexts. The law can help facilitate a shift in power relations. This is clearly present in legislation such as the Sterilisation Act 44 of 1998 which places the sterilisation choice in the hands of the affected person.

<sup>154</sup> Burchell op cit (n40) 223. Burchell points out that courts should be aware of the victim's vulnerabilities in relation to the offender. See *R v McCoy* 1953 (2) SA 4 (SR). The principle that submission is not consent is well established in the context of the crime of rape; see generally Snyman op cit (n39) 363-365.

<sup>155</sup> 1971 (2) SA 591 (A).

<sup>156</sup> Ibid.

<sup>157</sup> *S v S* supra (n155) at 591.

compelled to do what he ordered because she was afraid.<sup>158</sup> The court found that the policeman had intercourse with her against her will and that he intentionally used his authority against the woman as a means to secure her compliance with his order.<sup>159</sup> The policeman was found to have raped the woman because she had not voluntarily consented to the intercourse. *S v S*<sup>160</sup> demonstrates that consent will be lacking where a person expressly or tacitly uses his or her position of authority to pressurise a person into consenting.

Thus, it can be argued that consent will be lacking as a result of involuntariness, where health care providers, in their position of authority within the reproductive health care setting, intentionally adopt subtle means of coercion in order to obtain consent for sterilisation procedures. The American College of Obstetricians and Gynecologists specifically recognises the greater obligation of health care providers to facilitate a shift in power relations by providing sufficient information to bridge knowledge gaps, honest care and respecting the primacy of the patient's welfare.<sup>161</sup> This demonstrates that not all hierarchical relationships have to result in negative outcomes. Where sterilisations are performed as a result of abuse of authority, they may very well constitute criminal assault or a contravention of the Sterilisation Act 44 of 1998.

## 5 Conclusion

This article demonstrates that despite the fact that South Africa has the progressive, rights-affirming Sterilisation Act 44 of 1998 in place, women are being involuntarily sterilised and their human rights are being violated. It is noted that civil redress offers comfort via its compensatory mechanisms but more can be done in relation to involuntary sterilisations. In addition to compensation, perpetrators must be investigated and prosecuted. The Sterilisation Act 44 of 1998 and the common law are available in this respect.

Exploring avenues provided for in terms of the Sterilisation Act 44 of 1998 and the common law, this article reveals that there are two crimes available to victims of involuntary sterilisations. The common-law crime of assault is applicable to instances where women were involuntarily sterilised before and after the enactment of the Sterilisation Act 44 of 1998. However, s 9 of the Act provides the opportunity to secure up to five years' imprisonment for non-compliance with any provision of the

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<sup>158</sup> Ibid.

<sup>159</sup> Ibid.

<sup>160</sup> Supra (n155).

<sup>161</sup> The American College of Obstetricians and Gynecologists. ACOG Committee Opinion 'Informed consent' (2009) 439 1 at 6.

Act, which is not generally available for common assault. Regardless, the common-law crime of assault does offer recourse for those women who were sterilised before the enactment of the Sterilisation Act 44 of 1998, and should therefore, not be readily discarded.

This article demonstrates that if we want to go forward with prosecutions, the complexities of specific forms of medical treatment must be meaningfully explored through a criminal-law lens otherwise prosecutions might not be successful. The article found that on a practical level, there are obstacles to applying criminal-law principles to involuntary sterilisations particularly in the context of acquiring valid consent in the reproductive health care setting. There is a need to sift through the different role players in the consent-acquiring process for sterilisation procedures, determine their responsibilities and identify when those responsibilities have been breached.

Consent is central to medical treatment and serves as a defence against a charge of assault or a charge of contravening ss 2 and 4 of the Sterilisation Act 44 of 1998. Without identifying and working through the processes of acquiring consent, the relevant crimes will not find meaningful application. This article explored the role of nurses and doctors in relation to consent and demonstrated how the identified crimes are perpetrated in different settings and how the defence of consent may fail in those settings. This has not been done in a South African context, specifically in relation to involuntary sterilisations.

It is hoped that the arguments presented herein will encourage creative thinking on how to hold health care providers criminally liable when they knowingly perform sterilisations without valid consent. It is further hoped that academic debates go beyond merely recognising medical treatment without consent as assault, and grapple with the intricacies of applying specific criminal-law principles to this particular area of medical treatment. Without doing this, the application of the criminal law to these areas will remain untested and will not be viewed as a viable option in the fight against human rights violations.