Editorial
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Do we know the law on informed consent?

The current South African medicolegal climate is extremely hostile. The Department of Health continues to `haemorrhage' money much needed in our health system. It is easy to imagine how this system would benefit if the billions spent on medicolegal payouts were reduced. The SA Law Reform Commission's report on proposed legislative reform promises to mend some of these holes in the State's coffers.[1] The question we need to ask ourselves is, are we part of the medicolegal problem?

A survey by Mamoojee and Alli entitled: "Anaesthetists' knowledge of South African Law pertaining to informed consent in an academic centre" and published in this edition, reports that anaesthetists' knowledge of the law is 'suboptimal', suggesting that we are a contributory cause to our medicolegal crisis. In the 2017/2018 HPCSA annual report, 27 of 365 reported cases involved informed consent issues.[2] It is safe to assume that this figure is an underestimation of the gravity of the problem as this only reflects cases reported to the HPCSA. Interestingly, Mamoojee and Alli report that, while years of experience alone did not improve survey scores, respondents who attended postgraduate training on informed consent performed better.

Mamoojee and Alli set no minimum requirements on their assessment of the respondents, stating no allowance should be made for any deficiency in knowledge of the law considering the high rates of litigation. It is, however, possible to have an acceptable informed consent process without having complete knowledge of the law. It is also possible to have a poor informed consent process despite knowing every letter of the applicable law. This is because the law only provides threshold elements and minimum requirements and is not prescriptive regarding clinical application. While the elements of competence, voluntariness and appreciation are easier to grasp and translate into practice, disclosure is more difficult.[3] The question of what to disclose to patients, and how much detail, is unclear. This issue has been explored elsewhere in the literature.[4]

The informed consent process has shifted from the rigid paternalistic model to the shared-decision making model. The shared-decision model remains rooted in the four principles of bioethics while entertaining a patient-centred focus, albeit a time consuming approach; a luxury to most anaesthetists. Medical practice throughout the world has gradually shifted to this model of shared-decision making.[5,6] However, the western philosophical underpinning of the individual and self-determination are sharply contrasted against the African philosophy of Ubuntu and community-orientated beliefs.[7] Behren suggests a modification of the 4 principles of bioethics as laid down by Beauchamp and Childress to incorporate African philosophy as: respect for persons, beneficence, non-maleficence and harmony.[8] Any future developments in defining a patient satisfactory informed consent process must acknowledge alternative ethical philosophies. Literature on South African patient's perspectives in the area of informed consent is deficient and remains a fertile ground for explorative work.

Clinical practice guidelines regarding informed consent continue to be developed and updated worldwide. South African inform consent guidelines are freely available on the internet; but are not specific to anaesthetic practice.[9-11] The South African Society of Anaesthesiologists (SASA), in their most recent Clinical Practice Guideline update, published two appendices providing examples relating to consent.[12] While certainly a progressive step, these need to be developed further in line with anaesthesiologists' and patients' needs. This will also create standards on which programs educating clinicians on informed consent may be developed. Guidance specific to South African anaesthetic practice is crucial and will underwrite efforts of medicolegal risk mitigation.

Mamoojee and Alli once again raise awareness of our lack of medical law knowledge. Until medicolegal reform, clinicians would be wise to improve their knowledge of the law to guide their clinical practice to help steer clear of litigious patients and over eager legal representatives. Programs and interventions aiming to narrow the knowledge gap must aim to demystify the law and make it clinically applicable with practical guidance; a SASA taskforce may be instrumental in this regard. Evaluative studies of educational interventions are needed and South African patient perspectives on informed consent must be explored further.

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