

INFORMED CONSENT IN TEENAGE PREGNANCY

Dr CMD Mapodile

Moderator: Dr A Ramkisson



**UNIVERSITY OF
KWAZULU-NATAL**

**INYUVESI
YAKWAZULU-NATALI**

**School of Clinical Medicine
Discipline of Anaesthesiology and Critical Care**

CONTENTS

INTRODUCTION	3
TEENAGE PREGNANCY	3
Definition	3
The scope of the problem	3
Risk factors	4
Health implications	5
INFORMED CONSENT	5
Overview	5
The elements of informed consent	6
Mental/decisional capacity and informed consent	7
The South African law	8
Challenges of informed consent in anaesthesia	9
Doctors' knowledge, attitudes, and practices	10
CONCLUSION	12
REFERENCES	13

INTRODUCTION

Teenage pregnancy is a major public health concern as it involves a vulnerable population group in whom autonomy is more likely to be compromised. Certain parts of the laws pertaining to informed consent for procedures surrounding teenage pregnancy are not clearly defined, e.g., "capacity," creating the potential for error. This can lead to substandard patient care and an increase in litigation. A review of the literature has shown that there are no published studies to assess doctors' knowledge, attitude, and practices (KAP) of obtaining consent in pregnant teenagers. Most publications have broadly looked at different aspects of informed consent in the general adult and paediatric populations. Due to unclear definitions in the law, there is debate about what "informed consent" means for procedures involving teenage pregnancy.

Informed consent is legally and ethically required before any medical and/or surgical intervention to protect patients' autonomy. Doctors play a significant role in the process of informed consent, such as assessing patients' capacity to consent and providing them with enough information to freely make an informed decision. South African legislation has been very progressive in terms of informed consent in children for sexual reproductive health services by lowering the age of consent and not requiring a parent or guardian to consent in certain situations. There is a paucity of published data on whether doctors are aware of the laws pertaining to pregnant teenagers, whether these are appropriately applied in practice, and if doctors experience any difficulties. The inconsistent practices I experienced during my training and the lack of published data make it difficult to know the extent of the problem and develop viable solutions.

TEENAGE PREGNANCY

Definition

The United Nations International Children's Emergency Fund (UNICEF) defines teenage pregnancy as a girl aged 13 to 19 years who becomes pregnant[1]. The word "teenage" is synonymously used with "adolescent" and "child." However, depending on the organization or country, these terms have various meanings. In South Africa, the Department of Health defines an adolescent as a person between 10 and 19 years old, and a child as any person less than 18 years old[2].

The scope of the problem

About twenty-one million girls aged 15 to 19 and 2 million girls aged less than 15 years fell pregnant in developing regions during 2016 [3]. In the same year, South Africa had a teenage pregnancy rate of 23%, with more than half being unintended and the majority resulting in unsafe abortions[4].

Teenage pregnancy has decreased worldwide, especially in developed countries. In South Africa, there was a 7% decrease between 1984 and 2008. This was attributed to the increased use of contraception, more girls attending school, and getting married at an older age. However, teenage pregnancy remains high in developing countries.[3, 4]

Over the past few years, teenage pregnancy in South Africa has reached worrisome proportions. The Department of Basic Education reported that school-going girls gave birth to nearly 70,000 babies in 2013. This was a 26% increase from 2009. This situation is comparable in several South African provinces, particularly the Eastern Cape, Limpopo, and KwaZulu Natal, with over 17,000 teenagers becoming pregnant in KwaZulu Natal alone during 2010. Shockingly, one school had 144 pregnant students in 2006.[4]

TABLE 1

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH
Selected statistics on the sexual and reproductive health of young women in developing regions, 2016

	Africa	Asia	Latin America and the Caribbean	All
No. of women aged 15-19 (in 000s)	61,600	163,300	27,500	252,300
% ever had sex, age 16	27	11	28	17
% married, age 16	14	8	13	10
% ever had sex, age 19	66	41	67	50
% married, age 19	43	33	37	36
No. of pregnancies and outcomes among women aged 15-19 (in 000s)				
Pregnancies	8,900	8,300	3,600	20,700
Births	5,700	4,700	1,700	12,100
Abortions	1,900	2,400	1,400	5,600
Miscarriages	1,300	1,200	500	3,000
Percentage distribution of pregnancies, by intention status and outcome				
Intended	55	57	26	51
Births	46	48	22	42
Miscarriages	9	10	4	9
Unintended	45	43	74	49
Births	18	9	27	16
Abortions	21	28	38	27
Miscarriages	6	5	9	6
Total	100	100	100	100

NOTE: Numbers may not add up to totals because of rounding. SOURCE: reference 10.

www.guttmacher.org

Figure 1: teenage pregnancy rates and outcomes [3]

Risk factors

Teenage pregnancy has been linked to several factors, such as limited access to birth control, early sexual activity, girls' limited access to education, and other socioeconomic factors. Occasionally, sexual activity happens in the context of human rights violations, e.g., child marriage, forced sex, or sexual abuse.[4]

A study done in four African countries found that up to 38% of participants, including teenage girls, reported being forced to have their first sexual encounter[3]. In Nigeria, 87% of women marry, and nearly half become pregnant before the age of 18. In contrast to developed countries, the majority of teenage mothers are unmarried and their pregnancies are unplanned, often associated with excessive alcohol consumption [1].

Health implications

Worldwide, pregnancy and labour-related complications, e.g., unsafe abortion, infection, and postpartum haemorrhage, are the second leading causes of mortality among teenagers. However, these are less common when compared to older pregnant women.[1, 3]

Pregnant teenage girls are also at risk of postpartum depression, poor weight gain, pregnancy-induced hypertension, anaemia, and contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases because of unprotected sex[5]. In South Africa, women aged 15 to 24 years have the highest rate of new HIV infection, mainly through heterosexual transmission[4], with antenatal care attendants aged 15 to 19 years showing a 21% HIV seroprevalence[6].

Their infants fare poorly as well, with a 60% mortality rate and an increased risk of low birth weight, premature birth, and congenital anomalies.[1, 5]

INFORMED CONSENT

Overview

Since eighteenth-century England, Anglo-American law has mandated that doctors obtain consent from their patients before continuing with any medical intervention. Yet, the concept that a patient's consent should be informed to be considered legally valid dates back only to the 1950s, and a Californian appeals court stated: "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment." Later, in 1975, the courts established the reasonable person standard. i.e., information a "reasonable person" in similar circumstances would desire to know to make a decision[7].

Therefore, it is standard practice for doctors to provide mentally competent patients with information on diagnostic and/or treatment procedures, benefits, risks, complications and alternatives in non-emergency case. The focus on the patient illustrates the fundamental change that has happened in most Western countries from a physician-centred paternalistic approach to a patient-centred model that promotes autonomy and self-determination in the doctor-patient interaction. Under the legal premise that patients accept the risks related to the touching to which they freely agree, simple consent is still legally adequate to eliminate punishment for non-consensual touching, typically dubbed "battery" in civil (non-criminal) law and "assault" in criminal law. Interventions that exceed or deviate from what was agreed to continue to be punishable as assault or battery. Current law, however, has added the need for consent to be fully informed since the law of negligence has been expanded to demand that patients get appropriate disclosure of facts relevant to their choice of treatment. For example, a Canadian breadwinner had a stroke following a carotid endarterectomy. This risk was not disclosed, and the doctor was found to be negligent[8-10].

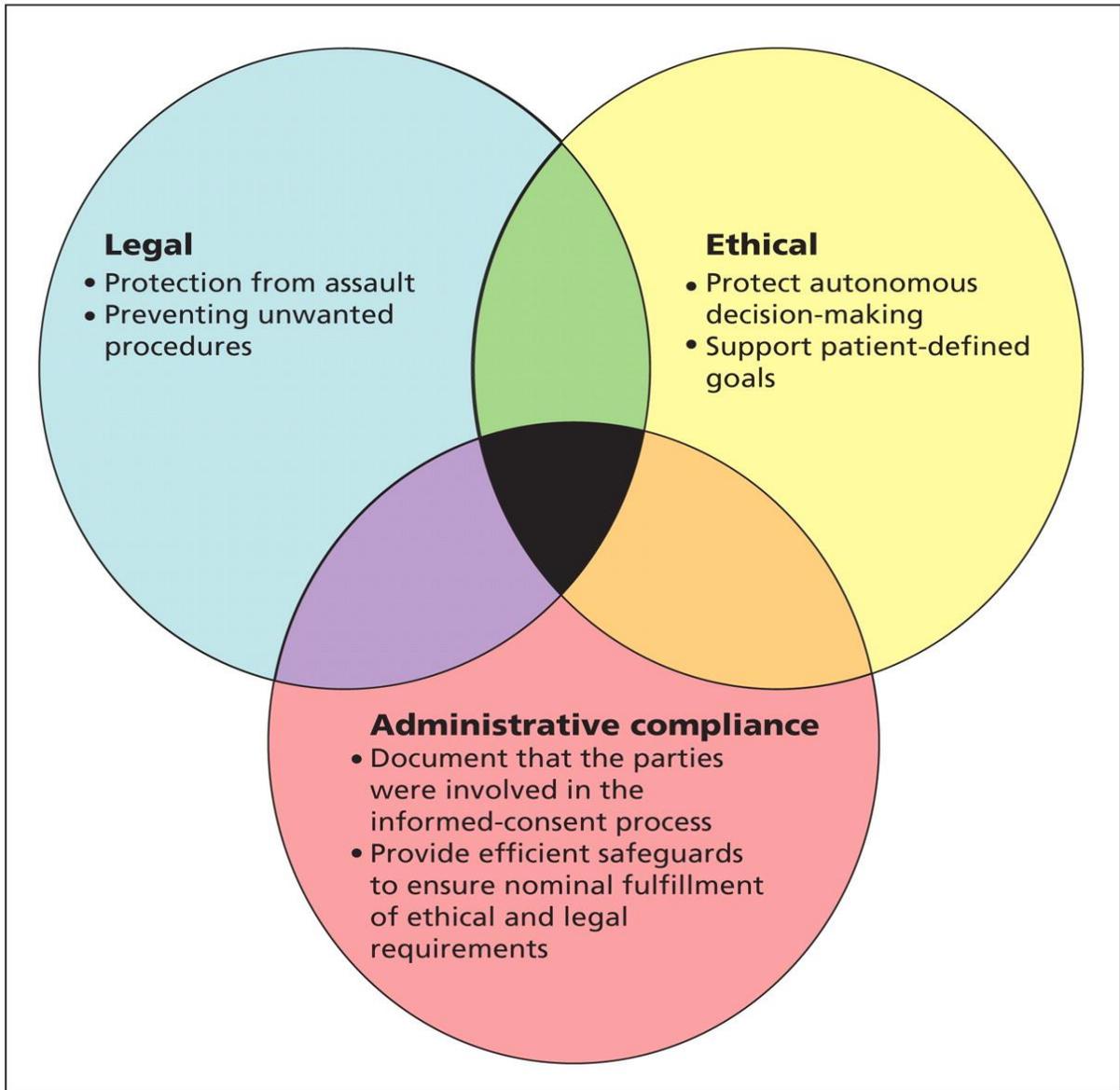


Figure 2: Venn diagram showing the multiple purposes of informed consent [7]

The elements of informed consent

In general, there are five elements that must be met for consent to be valid or fully informed.[8, 10, 11]

- Patients must be made aware of their condition and the planned diagnostic procedure and/or treatment, as well as the likelihood that it will be successful. Patients must also be made aware of the existence and nature of any risks involved, as well as the existence, potential benefits, and risks of any suggested alternative treatments (including the choice of no treatment). The information should be explained clearly, considering the patients' age, level of education, and mental capacity.
- Evaluation of the patient's comprehension of the information disclosed.
- Evaluation of the patient's ability to make the required judgment(s).
- Assure the patient, as much as you can, that they are free to choose from the available medical options without being forced or manipulated.

- Consent means that a person agrees to or disagrees with a planned treatment or procedure. Consent can be taken away at any time, and if it is, continuing treatment is illegal and unethical.

Mental/decisional capacity and informed consent

The legal age of maturity in South Africa is 18 years old. In terms of consent to clinical treatment, this means that people who are 18 or older should be assumed to be able to make decisions for themselves, unless there is reason to think they have a mental disability that affects their ability to make certain decisions.

In children, only those with adequate decision-making competence and legal authority can provide informed consent for medical care. In all other circumstances, parents or other surrogates offer informed consent for the diagnosis and/or treatment of children. Legislation determines the age component of legal capacity, i.e., the age at which the law grants rights and responsibilities to persons at certain periods of their life.

If a child has all the necessary decision-making capacities, i.e., he/she understands the relevant information, is able to appreciate the consequences of the decision, is capable of reasoning, and is able to express a preference, i.e., if a child is deemed competent to give informed consent, then the child is able to act in his/her best interest. Children who are not yet capable of independent decision-making should not be responsible for decisions they cannot make on their own. Then, others must decide in their best interests[12].

It is inappropriate to criticize a person's decision-making ability or lack thereof based on his or her age, appearance, illness, or behaviour. If there is doubt about a patient's decisional capacity, an evaluation should be conducted. In general, this entails providing knowledge to the patient, discussing it to assess his/her comprehension, and then asking pertinent questions to determine whether the patient has absorbed the material. Rather than focusing on the patient's choice, the emphasis should be on the patient's decision-making process; that is, not what the patient selects but how he or she decides.

The MacArthur Competence Assessment Tools consists of the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) and the MacArthur Competence Assessment Tool for Clinical Research (MacCAT-CR).

The MacCAT-T tests a patient's ability to make treatment decisions by looking at how well they understand, reason, appreciate, and choose. It was used to develop the MacCAT-CR, which measures participants' decision-making ability in clinical research [12].

The MacCAT-CR measures a child's level of competence more objectively. It has been shown to be accurate and easy to reproduce, but some researchers question its validity because it does not take into account how the child's values and emotions affect their competence. Children are divided into three groups that correlate with a certain age: those who are competent are 11,2 years and older; those who are not competent are usually less than 9.6 years old; and those who are the less competent are aged between 9.6 and 11,2 years. It can help healthcare providers when they are not sure what to do, and it can also be used to establish guidelines about how children can give informed consent[12].

The South African law

The South African Constitution, the National Health Act (NHA), various other statutes, the common law, and the HPCSA Guidelines all discuss patients' rights to informed consent. However, these are subject to interpretation and may not be well understood. Laws pertaining to consent for medical treatment and/or procedures are clear and straightforward for people above the age of 18 and above. So, in this section, I will briefly go over some of the most important conceptual, ethical, and legal issues related to informed consent for children, especially when it comes to services for their reproductive and sexual health.

Laws surrounding consent for health care services for children have changed over the years. Firstly, the widespread HIV/AIDS epidemic and urbanization have led to many children living with relatives, neighbours, and other caregivers instead of their parents and legal guardians. Secondly, children (persons under the age of 18 according to the constitution) have a greater capacity for decision-making than previously thought. Lastly, research has shown that children are becoming sexually active at younger ages, so it was necessary to lower the age of consent over the years to promote access to health care services and allow caregivers to consent to health treatment for young children in their care. [13]

The following acts are particularly important to know in teenage pregnant patients: The National Health Act (NHA) [No.61of2003], Children's Act (CA) [No.38of2005], and Choice of Termination of Pregnancy Act (CTOP) [No92of1996]

The South African Constitution, the highest law in the land, states that everyone has the right to access to health care services, including for reproductive health. Moreover, the National Health Act [No.61 of 2003] Section Seven clearly states that no healthcare service may be performed unless the patient consents to it, except in cases where the patient is unable to give consent i.e., failure to treat them will result in a health risk to the general population and/or delay in treating them will result in permanent bodily damage or death. Failure to obtain valid consent can result in legal action.

The Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) went into effect on April 1, 2010. It states that if a child aged 12 or older has the mental capacity to appreciate the risks and benefits of medical treatment and/or HIV testing, he or she may consent on their own behalf and to surgical treatment with the written assistance or permission of a parent or guardian. For surgery, both the child's consent and the parent's or guardian's assent must be written down and signed on Forms 34 and 35, respectively. If the child and parent/guardian disagree, the hospital superintendent, the Minister, or the high court must be contacted, depending on how urgent the procedure is. Unlike the previous law, the Child Care Act of 1983, they had to be older than fourteen to agree to medical care and older than 18 to agree to surgery. If they were younger than these ages, they had to get consent from their parents or legal guardians.

The Choice on Termination of Pregnancy (TOP) Act 92 of 1996 ensures that all women, regardless of age, have access to a safe and legal abortion if they have the mental capacity to consent. Children's Act 38 of 2005 does not apply to the TOP act because it would defeat the purpose of the act if only girls over 12 could agree to medical and/or surgical treatment to terminate a pregnancy.

However, these laws might make it hard for the attending healthcare provider. For example, there are no clear criteria for judging a child's capacity or maturity; there is no clear definition of what makes a procedure medical or surgical; and the clinician must find a balance between patient privacy and the duty to report child abuse.

Doctors' knowledge, attitudes, and practices

Doctors play a significant role in the process of informed consent, such as assessing patients' capacity to consent and providing them with enough information to freely make an informed decision.

A review of the literature has shown that there are no published studies to assess doctors' knowledge, attitude, and practices (KAP) of obtaining consent in pregnant teenagers. Most publications have broadly looked at several aspects of informed consent in the general adult and paediatric populations. Controversy exists regarding informed consent for procedures surrounding teenage pregnancy, due to unclear definitions within the laws.

A 2006 study by Harihatan et al. in Barbados demonstrated poor knowledge of healthcare ethics and law. It also suggested that doctors were more knowledgeable than the nurses[17]. In contrast a cross-sectional study by Haripriya and Haripriya in India demonstrated fairly good knowledge in doctors[18]. Those findings were similar to a study conducted in Cape Town in 1995 by Henley et al. who concluded that when asked to self-report, 70% of doctors believed they understood the legal requirements for informed consent[19]. However, other studies conducted in South Africa, demonstrate different findings.

Mamoojee and Alli concluded that the knowledge of anaesthetists of the South African law pertaining to informed consent is inadequate. They scored lowest on questions assessing knowledge of the CA and the NHA and higher on those assessing the Mental Health Act [No.17of2002]and CTOP Act[20].

Chima conducted a study in KwaZulu-Natal, examining the quality of informed consent across a range of clinical specialties and found there is inadequate knowledge about medical laws and regulations of the country. About 71% of participating doctors know the age of consent for routine medical treatment and shockingly only 30% know the age of consent for termination of pregnancy[11].

A Ugandan study revealed that nurses and occasionally anaesthetists obtained consent for surgery from patients despite having limited knowledge of its risks and advantages. As there are not many surgeons and they are often busy in the operating room, they get consent from about half of their patients. This is poor practice, as the individual doing the procedure or another person with the same level of competence must obtain consent. [21]

A patient's autonomy is important in the medical decision-making process and is valued by the South African constitution and laws pertaining to consent. However, a South African study by Chima found over 70% of doctors had paternalistic attitudes[11]. Similarly, a study conducted in 6 Croatian hospitals showed that 83% of the specialist physicians thought that patients would consent to the method recommended by them (18).

It is clear from the above studies that there are inconsistencies regarding healthcare workers knowledge, attitude and practices.

In summary doctors must fulfil the five key elements for valid informed consent as specified in the NHA. This includes first determining if the teenage pregnant patient has decision-making capacity and is of legal age to consent for that particular procedure according to the CCA or TOP act. If they are unable to consent, either the parent(s) or guardian must, and if they are unavailable, the hospital superintendent or minister must be contacted, depending on the urgency of the procedure. They must use straightforward language and document the informed consent procedure.

For more details, I recommend the following readings:

1. Consent to medical treatment in South Africa: an MPS guide
2. HPCSA Booklet 4.

CONCLUSION

Teenage pregnancy is still a global problem, especially in developing countries like South Africa. It can have a host of effects on the health of both the mother and the baby, which healthcare workers will see.

Informed consent is a legal and ethical requirement before any medical intervention. Due to their age and decisional capacity, it can be complex and challenging in the teenage pregnant patient. I have experienced inconsistent practices during my training and the lack of published data makes it difficult to know the extent of the problem and develop viable solutions. Hopefully, the results of my current research project on the topic will be helpful.

It is therefore important for us to know and keep up to date with changes in the law that may influence our medical practice when obtaining consent from them. This could be done through reading relevant advisory booklets, attending departmental meetings and workshops.

REFERENCES

1. Cook, S.M. and S.T. Cameron, *Social issues of teenage pregnancy*. *Obstetrics, Gynaecology & Reproductive Medicine*, 2015. **25**(9): p. 243-248.
2. Dawood, H., *Adolescent HIV treatment issues in South Africa*. *South African Medical Journal*, 2015. **105**(11): p. 953-953.
3. Singh, S. and J.E. Darroch, *Adding it up: costs and benefits of contraceptive services—estimates for 2012*. 2012.
4. De Wet, N., E.O. Amoo, and C. Odimegwu, *Teenage pregnancy in South Africa: Where are the young men involved?* *South African Journal of Child Health*, 2018. **2018**(1): p. s44-s50.
5. Dangal, G., *Teenage pregnancy: complexities and challenges*. Middle East, 2008. **56**: p. 1000.
6. Jewkes, R., et al., *Relationship dynamics and teenage pregnancy in South Africa*. *Social science & medicine*, 2001. **52**(5): p. 733-744.
7. Hall, D.E., A.V. Prochazka, and A.S. Fink, *Informed consent for clinical treatment*. *Cmaj*, 2012. **184**(5): p. 533-540.
8. Jukić, M., et al., *Knowledge and practices of obtaining informed consent for medical procedures among specialist physicians: questionnaire study in 6 Croatian hospitals*. *Croatian medical journal*, 2009. **50**(6): p. 567-574.
9. Dickens, B.M. and R.J. Cook, *Dimensions of informed consent to treatment*. *International Journal of Gynecology & Obstetrics*, 2004. **85**(3): p. 309-314.
10. Braun, A., L. Skene, and A. Merry, *Informed consent for anaesthesia in Australia and New Zealand*. *Anaesthesia and intensive care*, 2010. **38**(5): p. 809-822.
11. Chima, S.C., *Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study*. *BMC medical ethics*, 2013. **14**(1): p. 1-17.
12. Hein, I.M., et al., *Informed consent instead of assent is appropriate in children from the age of twelve: Policy implications of new findings on children's competence to consent to clinical research*. *BMC medical ethics*, 2015. **16**(1): p. 1-7.
13. Jamieson, L. and L. Lake, *Children's Act guide for health professionals*. 2013: Children's Institute, University of Cape Town.
14. White, S. and T. Baldwin, *Consent for anaesthesia*. *Anaesthesia*, 2003. **58**(8): p. 760-774.
15. De Roubaix, J.M., *Seeking patients' consent in anaesthesiology: consent in clinical practice*. *Southern African Journal of Anaesthesia and Analgesia*, 2005. **11**(4): p. 125-129.
16. Naidu, S. and P. Gopalan, *The perspectives of eThekweni public service anaesthetic doctors on the informed consent process for anaesthesia*. *Southern African Journal of Anaesthesia and Analgesia*, 2013. **19**(2): p. 96-101.
17. Hariharan, S., et al., *Knowledge, attitudes and practice of healthcare ethics and law among doctors and nurses in Barbados*. *BMC Medical ethics*, 2006. **7**(1): p. 1-9.
18. Haripriya, A. and V. Haripriya, *Knowledge about medical law and its negligence among doctors: A cross-sectional study*. *Int J Sci Res Publ*, 2014. **4**(5): p. 1-3.
19. Henley, L., et al., *Informed consent—a survey of doctors' practices in South Africa*. *South African Medical Journal*, 1995. **85**(12): p. 1273-1278.
20. Mamoojee, A. and A. Alli, *Anaesthetists' knowledge of South African Law pertaining to informed consent in an academic centre*. *Southern African Journal of Anaesthesia and Analgesia*, 2018. **24**(6): p. 155-164.
21. Wismayer, R., *Informed Consent for Surgical Care in East Africa*. 2021.