testing opportunities. The 'exceptionalisation' of HIV testing developed during an earlier period of therapeutic nihilism when the disadvantages of testing were thought to exceed the benefits of testing. A positive HIV diagnosis was known to impact negatively on quality of life but the therapeutic benefits accruing from knowledge of HIV status were limited and the preventive epidemiological benefits were undefined. The risk/benefit ratio of HIV testing began to change with increasing access to the benefits of co-trimoxazole prophylaxis and prevention-of-mother-to-child transmission (PMTCT) services. Access to antiretroviral therapy further increases the survival benefits conferred by knowledge of HIV-positive status. The benefit of increased population HIV testing by decreasing sexual risk behaviour has been demonstrated in the USA and other countries but has yet to be clearly shown within South Africa. Normalising HIV testing as part of routine medical care may also serve to reduce the stigma of HIV infection.

As the benefits of HIV testing increase at an individual and population level, so HIV testing strategies need to evolve. The challenge we face is to maximise the benefit dividend of effective HIV treatment while maintaining confidentiality and protecting human rights. Introduction of universal 'opt-out' HIV testing in all South African health care facilities may allow an opportunity to fulfil the individual right to the highest level of health and have public health benefit by impacting on prevention at a population level.


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### Advance directives and the National Health Act

**David McQuoid-Mason**

Advance directives are instructions given by patients regarding their future treatment should they become incompetent to consent to, or refuse, such treatment. Where a directive authorises a third person or proxy to give consent such person impliedly also has the authority to refuse consent.

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When applied to refusal of treatment, advance directives usually take the form of 'living wills' or enduring powers of attorney. While living wills represent the wishes of the patient, enduring powers of attorney appoint proxies to make decisions on behalf of the incompetent patient. In South Africa neither living wills nor enduring powers of attorney have been recognised by statute. It has been suggested that living wills should be recognised at common law – provided that they reflect the current wishes of patients. However, enduring powers of attorney cannot be recognised because at common law they become invalid when the patient becomes mentally incompetent.

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Nearly a decade ago the South African Law Commission made recommendations for the statutory recognition of both living wills and enduring powers of attorney but these have never been implemented by government. The National Health Act now introduces an informal method for the appointment of proxies to make health care decisions.

National Health Act provisions regarding mandated consent by proxy

The National Health Act provides a mechanism whereby patients may mandate a person in writing to consent to a health service on their behalf when they are unable to give such consent. This provision appears to overcome the Common law problem of enduring powers of attorney becoming invalid if a patient becomes mentally incompetent. However, the question arises whether this only applies to temporary mental incapacity or whether it also applies to patients who become permanently mentally incompetent.

The National Health Act states: ‘Subject to section 8, a health service may not be provided to a user without the user’s informed consent, unless the user is unable to give informed consent and such consent is given by a person mandated by the user in writing to grant consent on his or her behalf.’

Section 8 of the National Health Act states that if the informed consent is given by a person other than the user, such person must, if possible, consult the user before giving the required consent. The words ‘if possible’ indicate that the Act recognises that consultation may not be possible because the health user was mentally incompetent at the time the consent was required.

Section 8 of the National Health Act also provides that if users are unable to participate in a decision affecting their health and treatment, after the service they must be provided with full knowledge in terms of section 6 – unless it would be contrary to the patient’s best interests. This means that patients must be told their health status; the range of diagnostic procedures and treatment options; the benefits, risks, costs and consequences of such options; and their right to refuse health services together with an explanation of the implications, risks, and the obligations of such refusal. There is no reference to ‘if possible’ in this section so it could be argued that there is an expectation that the patients will not be permanently incompetent and that the information must be provided on their recovery. However, if a patient does not recover mental capacity it would clearly be impossible to provide the information. In such circumstances, would the mandated consent continue or would one of the other persons mentioned in the National Health Act be required to give consent?

Does the mandated consent by proxy apply to patients who become permanently mentally incompetent?

Where the patient was mentally competent at the time that he or she mandated the proxy (in writing) to consent to treatment on his or her behalf, the National Health Act is clear – the mandated proxy consent prevails. According to the Act the categories of persons mentioned as having precedence regarding the giving of consent (i.e. a spouse or partner, a parent, a grandparent, an adult child or a brother or sister of the user) are only required to give consent if ‘no person is mandated or authorised to give such consent’. This means that if a person has been mandated in an advance directive to give consent he or she will take precedence over anyone else. (An ‘authorised’ person is a person ‘authorised to give such consent in terms of any law or court order’ (e.g. a curator)).

The written mandate to the proxy by the health service user continues to operate whether or not the health user is temporarily or permanently mentally incompetent. It is similar to an enduring power of attorney without the legal formalities (and costs) of the latter. No formalities are required – other than that the mandate be in writing. It would be prudent, however, to have the mandate dated and signed by the patient and two witnesses.

Who may mandate consent by proxy?

According to the Child Care Act minors over the age of 14 years may consent to medical treatment and those over 18 years of age to operations. Therefore, health users requiring medical treatment may appoint proxies if they are 14 years old or more, and users aged 18 years or more may appoint proxies for operations. In terms of the Choice on Termination of Pregnancy Act girls of any age may consent to a termination of pregnancy. Thus patients of any age undergoing a termination of pregnancy may appoint a proxy. However, in all these cases the patients must be mentally mature enough to understand the nature and effect of the proxy mandate as well the treatment or operation that they are about to undergo.

Proxy mandates may include directions regarding refusal of treatment. However, in the case of children under the age of 18 years directions regarding refusal of treatment may be subject to the Constitutional provisions regarding the ‘best interests’ of the child.

Conclusion

The National Health Act provides a cheap and effective way for patients who may become mentally incompetent during (or as a result of) a health service, to appoint proxies to make decisions on their behalf. All that is required is that the mandate be in
writing and that the patient be legally and mentally competent at the time that he or she executes it. Such proxy mandates take precedence over the wishes of relatives or partners and are binding – whether the patient is temporarily or permanently unable to give consent – unless a court orders otherwise.

4. Section 75(1)(a) of the National Health Act 61 of 2003.
5. Section 82(5)(m) of the National Health Act 61 of 2003.
6. Section 83(1) of the National Health Act 61 of 2003.
7. Section 6(3) of the National Health Act 61 of 2003.
8. Section 70(1)(b) of the National Health Act 61 of 2003.
9. Section 70(1)(k) of the National Health Act 61 of 2003.
10. Section 39A(1) of the Child Care Act 74 of 1983.
11. Section 90(1) of the Choice on Termination of Pregnancy Act 96 of 1996.

FROM GENERAL PRACTICE

Basking in glory

Chris Ellis

So far my general practice has given me the opportunity to make some crashing _fouxx pas_ and to undergo sundry random humiliations. I once introduced myself to a woman, who I thought was a new patient, by saying ‘I’m Chris Ellis’, to receive the reply ‘Yes, I know you are Chris Ellis, you delivered my baby 6 weeks ago and I have come in for my postnatal check-up.’ It’s a difficult position to recover from, but in my defence she had arrived in the practice late in pregnancy, had only one antenatal with me, and was a quick normal delivery.

To balance these setbacks, every now and again there are some small triumphs or compliments. A compliment used to keep me going for about a month but now I need them more frequently (like daily). Triumphs still last a little longer, and false modesty will not prevent me from telling you about one.

In my general practice I have a reasonable proportion of high-income patients and I do a lot of small office procedures and operations. A while ago two of my female patients from the village had obviously been discussing things over coffee. They came to see me separately, and each asked for moles to be removed from her face. I gave them the choice of having the moles removed by me or being referred to an excellent plastic surgeon. One of them, who is one of my Giorgio-Armani, cashmere-sweater and gold-wrist-bangle patients, opted for the plastic surgeon, and the other chose me.

I proceeded to remove three moles from this woman’s face with the magnificent dexterity and flair for which I am known. The other patient proceeded off into the halls of pinstriped suits and vases of gladioli in the waiting room. About 2 months later I heard, on the village grapevine, that there had been a comparing session at another Ladies Skin and Cosmetic Society coffee morning. They couldn’t see any scars where the moles had been removed on my patient, whereas the other patient had perceptible facial scars. On hearing this news I gleefully indulged myself in some serious basking. To say the least this was unfair to my colleague. Human tissue heals in different ways and often it has little to do with the operator. If this had been the other way round I would be in a grade 5 suck and not be writing this article.

While I am on a roll of self-congratulation let me tell you of another triumph that comes to all of us all time to time. The patient has seen the first doctor for fever and feeling unwell and has been sent off with paracetamol and some advice, and then sees doctor number 2 a few days later for aches and pains and is sent off with paracetamol and some more advice. On about day 6 the patient then sees you with the typical clusters of shingles vesicles, and you step in with this miraculous diagnosis made with just the right amount of perspicacity and clinical acumen. You modestly accept the compliments of the patient and their recognition of your extensive diagnostic powers.

Shingles is not the only condition from which you can reap these rewards. You can do it with roseola and glandular fever as well, as they have a longish prodromal period.

There is just one problem to all this. I hate it when I am doctor one or two.

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