An examination of mature children's capacity to consent to medical treatment in South Africa

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Dedication

Memories of those that believed in us, will always be with us forever. I would like to dedicate this paper to my late grandfather, Gaitsiwe Monnahela, who was very close to my heart. He always encouraged me to have self believe and study further.

I wish to extend my dedication to my mother, Sherley Leine; my grandmother, Elva Monnahela and my brother, Kamogelo Monnahela. Their love and support helped me to complete this paper.

ABSTRACT

This research aims to examine the capacity of children to consent to their own medical treatment based on maturity. It directly examines section 129(2) of the Children's Act. The main question in this research is whether the presumption/provision in section 129(2) of the Children's Act, which states that children who are under the age of 12 do not have the necessary ability to decide on medical treatment, prevent them from exercising their autonomy rights in medical treatment decisions?

The research provides that children's autonomy rights are not subject to any age. The provision of section 129(2) of the Children's Act is proved to be in opposition with the autonomy rights of children and infringes their constitutional rights.

The research considers the provisions of international and regional treaties and takes into account lessons learnt by Canada and the United Kingdom regarding the issue of children's right to consent their own medical treatment and indicates how such lessons can be adopted in South Africa.

Chapter 1: Research outline and context

1.1 Introduction

Everyone, including children, have a self-governing freedom to decide what they want to do with their bodies.[1] This implies that consent must be acquired from individuals before any medical procedure is performed on their bodies.[2] In a medical procedure, the ability of children to decide on a medical treatment is assessed based on two requirements, maturity and age (12 years and above). Therefore, irrespective of the autonomy rights children have, they are considered as lacking the required capacity to decide on what medical treatment is best suited for them if they are under the age of 12.[3]

Thus, this research aims to examine the capacity of children to consent to medical treatment based on maturity.

1.2 Research Question

To what extent does an examination of children's capacity to consent to medical treatment based on age and not maturity infringe the autonomy rights of children?

1.3 Problem Statement

At common law, children irrespective of age were thought to have insufficient ability to authorise a medical treatment that can be performed on them. This resulted in parents obtaining the power to authorise medical treatments that can be performed on their children.[4] However, as years passed, things changed, age was set as a determining factor.[5] According to the *Child Care Act*,[6] children at the age of 14 years and above were regarded as individuals who are qualified to decide on what medical treatment is best suited for them without assistance from guardians or parents.[7]

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1 Buchner-Eveleigh 2019 *De Jure Law Journal* 242.
2 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 8.
3 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 8.
4 Kruger 2018 *PER* 2.
5 Kruger 2018 *PER* 2.
6 *Child Care Act* 74 of 1983 (hereinafter the *Child Care Act*).
7 Section 39(4) (b) of the *Child Care Act*.

Later in 2005 *Children's Act* came into operation.[8] Children over 12 years are now given the right to decide on what medical treatment is suited for them. This is on the basis that they understand the dangers and gains of the medical treatment, and also, they must show adequate maturity.[9] Thus, this implies that 12 years was set as the benchmark age in which a child can acquire the ability to decide on what medical treatment is suitable him or her.

Furthermore, a child needs to be competent to have the right to agree to medical treatment.[10] Therefore, by implication, the *Children's Act*[11] considers a child under the age of 12 to have insufficient ability required to agree to a medical treatment

As children grow, it becomes imperative that they have the right to express their views and make decisions on problems that affect them. This is referred to as autonomy rights.[12] Children's autonomy rights are not subject to age. Moreover, contrary to the *Children's Act*[13] discussed above, the children's autonomy rights guarantee them that they can make independent decisions without their parent's approval.[14] However, children face difficulties when they exercise their autonomy rights in medical treatment decisions. In the case of *Christian Lawyers Association v Minister of Health*,[15] the court contended that for one to acquire the right to give informed consent, he/she must have the right mental capacity. Furthermore, the court argued that people differ; some people mature quicker than others do.[16]

This raises questions, the first being, does the presumption/provision in section 129(2) of *Children's Act,* which states that children who are under 12 years do not have the necessary ability to decide on medical treatment, prevent them from

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8 SAMA 2012 *SAMA* 4-5. In 2003, Parliament received the Children's Bill which was divided into two parts. The first part of the part focused on what the national government must deal with. The second part focused on the provincial government, named the Children's Amendment Bill. In 2005 the President approved the Children's Act. However, the first part of the Children's Act commenced on 1 July 2007 and the second part came into effect on 1 April 2010.

9 Section 129(2) of the *Children's Act* 38 of 2005.

10 Beyer 2014 *Community Medicine & Health Education* 2.

11 *Children's Act* 38 of 2005.

12 Ganya, Kling and Moodley 2016 *BMC medical ethics* 2.

13 *Children's Act* 38 of 2005.

14 Ganya, Kling and Moodley 2016 *BMC medical ethics* 2.

15 *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T).

16 *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T) para 20.

exercising their autonomy rights in medical treatment decisions? Secondly, how does section 129(2) of *Children's Act*[17] infringe the constitutional rights of children under 12 years who can make independent decisions but are denied such a right? Lastly, what are the factors that can lead to the maturity of a child before the age of 12?

In the jurisdiction of Canada, in *AC v Manitoba*,[18] a girl at the age of 14 who was experiencing lower gastrointestinal bleeding, refused medical treatment. The reason for refusing was that, the proposed treatment was in contradiction with her religious beliefs.[19] The Canadian Supreme Court adopted the '*Mature Minor' doctrine*, which stipulates that children must be permitted to share their views given that they are fully aware and understand the dangers and benefits of consenting or refusing proposed medical treatment irrespective of their age or whether their decision goes against their parents or guardian.[20] Furthermore, *Gillick v West Norfolk and Wisbech Area Health Authority's*,[21] case in the United Kingdom, an issued circular ordered health care facilitators to give contraceptives to girls who are under 16 years without permission from their guardian or parents. An application was sought in which the plaintiff argued that any girl child below the 16 years does not have the authority to take/consume contraceptives without consent from their parents and that the circular was unlawful.[22] The United Kingdom court implemented a principle called '*Gillick Competence*'. This principle assesses children's ability to decide on what medical treatment is suited for them based on maturity, and level of understanding and not on age.[23] When a child is *Gillick competent*, he or she must have shown an in-depth comprehension and appreciation of all the dangers and benefits that come with the treatment. Furthermore, the child needs to be aware of the psychological, emotional and social implications that may be a result of the medical decision taken.[24] Therefore, this research uses these two mentioned jurisdictions as they are

17 *Children's Act* 38 of 2005.
18 *AC v Manitoba (Director of Child and Family Services)* (2009) SCC 30.
19 *AC v Manitoba (Director of Child and Family Services) (2009) SCC* 30 para 5.
20 *AC v Manitoba (Director of Child and Family Services)* (2009) SCC 30 para 80.
21 *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC (HL) 112.
22 *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC (HL) 112 para 30.
23 *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC (HL) 112 para 90.
24 *Gillick v West Norfolk and Wisbech Area Health Authority* (1986) AC (HL) 112 para 95.

related to the research topic. The lessons learned by these jurisdictions will contribute to South African law. This will help South Africa deal with children's consent to medical treatment.

The study further refers to international and regional treaties, namely the Convention on the Rights of a Child (CRC) and the African Charter on the Rights and Welfare of a Child (ACRWC). It outlines how these two international and regional instruments protect children's participation rights in matters affecting their wellbeing. These instruments ensure that every child is afforded an opportunity to convey their opinions without interference, and those views must be taken into consideration.[25]

The study makes recommendations on how the legal system in South Africa should approach matters concerning children's ability to decide on what medical treatment is best suited for them.

1.4 Framework of the Study

Chapter 1 of the research introduces the research topic. It discusses the research title, research question, problem statement, framework of the study, research methods, and relevance to the research unit theme and the statement regarding ethics.

Chapter 2 discusses the legislative and constitutional framework on the rights of children to consent to medical treatment. It discusses the relationship between autonomy, competence, and informed consent of children in decision-making. Moreover, it also analyses the rights of children to participate and consent to medical treatment as indicated in the *Children's Act*.[26] It concludes with the discussion of children's constitutional right to life, dignity, security and control over their body and lastly, the best interest of the child principle.

Chapter 3 discusses international Conventions and the position in Canada and the United Kingdom regarding children's consent to medical treatment. This chapter

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25 Article 12 of the *CRC* (1989); article 4(2) and article 7 of the *African Charter* (1990).

26 *Children's Act* 38 of 2005.

consists of the discussion of the Convention on the Rights of a Child (CRC) as well as the African Charter on the Rights and Welfare of a Child (African Charter). In addition, the chapter focuses on among others, articles 4(2), 7 of the African Charter and Article 12 of the CRC, which gives every child the right to express their views and the right to have those views considered. In closing, it discusses the position in Canada and the United Kingdom in order to determine whether South Africa can benefit from them or improve its laws.

Chapter 4 is the concluding chapter. It provides a summary of the study, findings, and recommendations.

1.5 Research Methodology

This research used legislation, case law, journal articles, books, dissertations, reports, and internet sources. The research is not a comparative study, but lessons learnt from other jurisdictions.

1.6 Statement on research ethics

In this research, no interviews were conducted. A research methodology was adapted.

1.7 Relevance for the Research Unit

This research is in the Research Unit: Law, Justice and Sustainability within the Vulnerable Societies project. It aims to analyse the rights of children, as a vulnerable group to agree to medical treatment irrespective of their age. The output of the research unit was derived from written books, journal articles, legislation and case law on the issue of children's rights.

CHAPTER 2: Legislative and constitutional framework on the rights of children to consent to medical treatment

2.1 Introduction

Firstly, as an entry point, a brief definition of the terms: autonomy, competence, and informed consent will be supplied. Thereafter, this chapter will deduce how those terms are linked to the right of children to consent to a medical treatment. Furthermore, it focuses on the *Children's Act*,[27] particularly sections 10 and 129(2). Lastly, it discusses the rights accorded to the children by the Constitution.[28] These are the right to dignity,[29] the right to life,[30] the right to bodily and physical integrity,[31] and the best interest of the child principle[32] in all affairs pertaining medical treatment for children.

2.2. A brief explanation of concepts

2.2.1 Autonomy

Autonomy means to have self-determination.[33] For a person to have autonomy that person has to reason on his or her own, be free from external constraints and have access to information.[34] Kruger[35] has a perspective that autonomy signifies the right of children to make independent decisions without help from their parents, guardians or any third party.[36] The Constitution does not specifically discuss children's autonomy right. However, as with any person, children develop their personal autonomy from the right to life,[37] dignity,[38] freedom of religion,[39] and

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27 *Children's Act* 38 of 2005.
28 *Constitution of the Republic of South Africa*, 1996 (herein after referred to as the Constitution).
29 Section 10 of the *Constitution of the Republic of South Africa*, 1996.
30 Section 11 of the *Constitution of the Republic of South Africa*, 1996.
31 Section 12(2) of the *Constitution of the Republic of South Africa*, 1996.
32 Section 28(2) of the *Constitution of the Republic of South Africa*, 1996.
33 Kruger 2018 *PER* 3.
34 Kruger 2018 *PER* 3.
35 Kruger 2018 *PER* 3.
36 Spemars *A critical analyses of South African Mental Health Law* 75.
37 Section 11 of the *Constitution of the Republic of South Africa*, 1996.
38 Section 10 of the *Constitution of the Republic of South Africa*, 1996.
39 Section 15 of the *Constitution of the Republic of South Africa,* 1996.

bodily and psychological integrity,[40] which is discussed later in this chapter. Autonomy, therefore, implies that any child can decide independently on which medical treatment they prefer if that they are competent.

2.2.2 Competence

Buchanan and Brock[41] define competence as the determination of a person's ability to decide on a specific matter at a certain time.[42] Furthermore, Buchanan and Brock divide competence into three capacities, the capacity to comprehend and communicate, the capacity to reason and think, and the capacity to know what is good and harmful.[43] It can be concluded that competence depends on situations (i.e., its situation-specific). Therefore, this means that for a patient to be considered competent to make medical decisions, he or she needs to have shown all three capacities.[44] Furthermore, the patient must have a good plan for the future and take his/her best interests into consideration.[45]

2.2.3 Informed consent

Informed consent implies that an individual is autonomous and, therefore, can make decisions on things that affect them. This is if such a person meets the requirements of informed consent.[46] According to Ganya,[47] the requirements of informed consent are, the capacity to understand, and acknowledge communicated information, the capability to demonstrate a view and make decisions freely.[48] This entails that a child must have the maturity to comprehend and appreciate the advantages and disadvantages of the medical treatment.[49]

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40 Section 12(2) of the *Constitution of the Republic of South Africa*, 1996.
41 Buchanan and Brock *Deciding for Others*.
42 Buchanan and Brock *Deciding for Others* 18.
43 Buchanan and Brock *Deciding for Others* 18.
44 Swanepoel 2011 *Obiter* 290.
45 Swanepoel 2011 *Obiter* 290.
46 Ganya 2016 *BMC Medical Ethics* 4.
47 Ganya 2016 *BMC Medical Ethics* 4
48 Ganya 2016 *BMC Medical Ethics* 4.
49 Kruger 2018 *PER* 8.

In *Esterhuizen v Administrator, Transvaal*,[50] the court dealt with the matter of informed consent in children's medical treatment. The matter concerned a girl who was 14 years old. At the age of 10, she injured her left ankle and developed a small nodule. This nodule then started developing on her right leg. She then had to undergo x-ray treatments for the lumps/ nodules underneath her legs, which did not have any side effects. However, after a few years, new nodules developed. The girl's grandfather, who was the guardian at that time, as the mother was out of the country, decided to take her to the hospital for treatment. The doctor then decided to change the treatment and use a radical x-ray treatment in an attempt to fight the illness. However, the doctor did not inform the child's mother or grandfather of the potential dangers and benefits of the treatment. When the 14-year-old girl questioned the doctor on the outcome after she has undergone the treatment, the doctor said she should not worry.[51]

Ten days later, after the treatment was done, the girl began experiencing blisters, which gave rise to a raging sensation on her skin. She was then taken back to the health centre, where two of her legs were amputated due to the treatment. Five years later, the girl was without her two legs, a left hand, and there existed a possibility that her right hand would also be amputated. [52]

When the doctor was cross-examined on why he did not inform the grandfather or the mother of the girl about dangers and gains of the treatment, he said that he had not seen the girl's parents before and that in the radiotherapy department they were not obliged to invite parents for discussions. Furthermore, he was completely knowledgeable of the advantages and disadvantages of the radiotherapy as it was his duty to heal the illness. Thus, he did not see it necessary to inform the parents of the advantages and disadvantages of the radiotherapy.[53]

When the court examined the reckless disregard of the doctor as he failed to obtain informed consent from the patient, it held that a doctor has an obligation to obtain

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50 *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710.

51 Preez *The Medical Treatment of Children* 12.

52 Preez *The Medical Treatment of Children* 12.

53 *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 Idem 717A; Preez *The Medical Treatment of Children* 13.

first an informed consent from a patient before conducting any medical procedure. Furthermore, he or she must explain the advantages and disadvantages of the treatment to the patient, irrespective of how dangerous it is. Moreover, it emphasised that a doctor who does not obtain a patient's consent before conducting a treatment act at his or her risk. The law will not protect him or her in this instance.[54]

The depth of the requirements for an informed consent was at the pinnacle of the case of *Castell v De Greef*.[55] The court held that, the patient must comprehend and appreciate the level of pain to which he or she is agreeing to for informed consent to exist. Furthermore, the patient has to receive advice from the doctor on any threat of danger that may result from the treatment.[56]

According to the *National Health Act*,[57] the health care provider has a duty to communicate with the patient, the status of their health. Moreover, the patient must be informed of all the possible treatments that can be used, as well as their disadvantages and advantages.[58] Furthermore, the health care provider has a duty to enlighten the patient of his or her right to refuse medical treatment along with the advantages and disadvantages that come with that.[59] The health care provider must at all times communicate with the patient using the language that he or she can apprehend. The health care provider must be considerate of the patient's level of literacy.[60] Therefore, the National Health Act outlines duties the health care provider must do in order to receive consent from a patient.

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54 *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 Idem 717A; Preez *The Medical Treatment of Children* 13.

55 *Castell v De Greeff* 1994 4 SA 408 (C).

56 *Castell v De Greeff* 1994 4 SA 408 (C) para 426F-H.

57 *National Health Act* 61 of 2003.

58 Section 6(1)(a) of the *National Health Act* 61 of 2003.

59 Section 6(1) (d) of the *National Health Act* 61 of 2003.

60 Section 6(2) of the *National Health Act* 61 of 2003.

2.3 Children's Act 38 of 2005

Section 10 of the *Children's Act,*[61] which affords children the right to participate in matters that affect them, is discussed and analysed next. Thereafter, follows an examination of section 129(2) of *Children Act*,[62] which concentrates on children's right to consent to medical treatment.

2.3.1 Right to participation

The right of children to participate is stipulated in *Children's Act* section 10. It states that all children have a right to participate in all matters that affect them, and their view must be considered.[63]

Children's right to participation can be the lawful ability to make choices on issues that affect their lives, and it is expressly provided in section 10 of the *Children's Act*.[64] The phrase 'age, maturity and stage of development' introduces the idea of the 'evolving capacities' of children into the legal system of South Africa.[65]

Section 10 does not specify the age at which children can participate.[66] Therefore, it can be concluded that all children, irrespective of their age can participate in decisions that affect them, most importantly, the right to consent to medical treatment. This notion is reinforced in section 31 of the *Children's Act,*[67] which provides that parents or guardians must when taking decisions that affects the child, involve him or her in the decision-making process. The parents or guardians must be considerate of the desires of the child.

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61 Section 10 of the *Children's Act* 38 of 2005, "Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration."

62 *Children's Act* 38 Of 2005.

63 Section 10 of the *Children's Act* 38 Of 2005.

64 Van der Watt *The child's right to self-determination* 11.

65 Moyo 2015 *SAJHR* 175.

66 Kruger, 2018 *SALR* 175.

67 *Children's Act* 38 of 2005.

This was supported in case of *De Groot v De Groot*,[68] were the court emphasised that it supports the *Children's Acts*[69] provision that full attention must be offered to the desires of children who show an understanding of matters in front of them, irrespective of their age.[70]

Children have the right to take part in an appropriate way as provided by section 10 of the *Children's Act.*[71] According to Mayo,[72] the state must ensure that the age and developing competencies of the child are considered when he or she participates. Furthermore, this imposes a responsibility on the state make certain that the courts and other important structures are considerate of children.[73] This implies that the courts must listen to the child when he/she wants to agree to medical treatment. Furthermore, the courts need not to rush in overruling such request considering that the child has evolving capacities. It has been argued that the longer a child lives with an illness, the more in-depth knowledge of the illness he or she acquires.[74] Therefore, denying a child to participate in a medical decision simply because of age is an infringement to their right to participate.

Children's participation rights evolve. This means that, as children grow, the less dependent they become and this qualifies them as full holders of rights.[75] Parents ought to consider that children have evolving capacities, which indicates the child's increasing need for autonomy towards maturity. As a child matures into an autonomous person, the decisions he or she makes are fundamental to the right to participation.[76] Therefore, parents must not deny children the right to participate as they evolve daily. Section 10 justifies the autonomy right children have when it comes to making decisions that affect them. Furthermore, it justifies that the state must not interfere with the child's preferences if they are in the child's best interest.

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68 *De Groot v De Groot* (unreported) (ECHC) Case number 1408/2009 of 10 September 2009.
69 *Children's Act* 38 of 2005.
70 *De Groot v De Groot* (unreported) (ECHC) Case number 1408/2009 of 10 September 2009 para 17 and 23.
71 *Children's Act* 38 of 2005.
72 Moyo 2015 *SAJHR* 178.
73 Moyo 2015 *SAJHR* 178.
74 Beyer 2014 *Community Med Health Educ* 4.
75 Moyo 2015 *SAJHR* 175.
76 Van der Watt *The child's right to self-determination* 13.

In addition, it is wrong to predict that children may only participate in matters that are inconsequential and not those that have a huge impact on their lives.[77]

2.3.2 Right to consent to medical treatment

As provided by the *Children's Act*,[78] a child has to satisfy two requirements in order to agree to medical treatment. The foremost requirement is, the child must be 12 years or older; secondly, the child must have adequate maturity and mental capacity to comprehend the dangers and gains the medical treatment. However, there are loopholes in the definitions provided by the *Children's Act*.[79] The *Children's Act*[80] does not give details of what it meant by medical treatment. For the purpose of this research, the definition provided by Kruger is considered. He states that medical treatment consists of harmless procedures that comprise of receiving blood, injections and psychological treatment.[81]

Moreover, the *Children's Act*[82] does not give clear a definition of what is 'sufficient maturity'. Furthermore, the Act does not stipulate how maturity of a child is determined. Therefore, it can be concluded that there is no protocol for assessing a child's maturity. Moyo[83] argues that as children grow, their capacities evolve. Moyo argues that using age as an instrument to determine decision-making capacities makes it difficult to identify children who have acquired maturity before the age of 12. He further states that the lack of measures in determining children's maturity may result in courts not considering the desires of a child below 12 years who can make rational decisions.[84]

The *Children's Act*[85] only allows children at the age of 12 and above to independently consent to a medical treatment without help from a guardian or parent. The Act only considers children who are 12 years and above to have

77 Reyneke 2013 *De Jure* 221.
78 Section 129(2) of the *Children's Act* 38 of 2005.
79 Ganya 2016 *BMC Medical Ethics* 2.
80 *Children's Act* 38 of 2005.
81 Kruger 2018 *PER* 21.
82 *Children's Act 38 of 2005*
83 Moyo 2015 *SAJHR* 180.
84 Moyo 2015 *SAJHR* 180.
85 *Children's Act* 38 of 2005.

decision-making capacities. The responsibilities and rights of children below 12 years rest with their parents, while those that are at age 12 and above are independent and receive limited protection.[86] Moyo[87] believes that if the focus is on maturity, all children regardless of their age will be given a chance to use their autonomy in matters that affect them.[88] Bayer,[89] on the other hand, believes that only children who are severely ill, before they are diagnosed, have an in-depth comprehension of the dangers and gains of the treatment.[90] Thus, Bayer only accommodates children who are severely ill.

Children's competence is determined by their experience. A child with cancer and has undergone treatments makes a great example of the level of maturity. This particular child can consent or refuse cancer medical treatment based on the experiences he or she has encountered. The experience that a child acquires is the one that leads to maturity and not the age.[91] Therefore, the requirement of 12 years can be criticised because it makes no room for the probability of children maturing before 12 years. Parents and the courts need to consider the possibility of children maturing before the stipulated age by the *Children's Act*.[92] If such children exist, then courts and parents should allow them to express their views regarding their own medical treatment.

2.4 The Constitution

According to section 7(1) of the Constitution, the Bill of Rights contains, protects, and promotes all human rights in South Africa. It further guarantees democratic human dignity, equality and freedom values for all South Africans. The State is obliged to respect, defend, encourage and enforce the rights found in the Bill of Rights.[93] Children are the most vulnerable beings; as such, their rights should be

86 Moyo 2015 *SAJHR* 180.
87 Moyo 2015 *SAJHR* 180.
88 Moyo 2015 *SAJHR* 180.
89 Beyer 2014 *Community Med Health Education* 3.
90 Beyer 2014 *Community Med Health Education* 3.
91 Beyer 2014 *Community Med Health Education* 3.
92 Section 129(2) of the *Children's Act* 38 of 2005.
93 Section 7(2) of the *Constitution of the Republic of South Africa*, 1996.

recognised and protected.[94] Section 28 of the Constitution, therefore, includes rights intended for children. However, even though children are afforded rights in section 28, it does not limit them from protection by other rights provided in the Bill of Rights.[95] These rights include the right to life,[96] the right to dignity,[97] the right to bodily and psychological integrity,[98] the best interest of the child principle.[99] These provisions are discussed below.

2.4.1 Right to life

Every individual is conferred the right to life in section 11 of the Constitution.[100] The right to life is considered the basic right for human rights. The motivation behind this right is, it provides existence to all other rights.[101] The Constitutional Court in the case of *S v Makwenyane,*[102] pronounced that the right to life and dignity are the fundamental and most powerful and basic important of all human rights. Furthermore, in the Bill of Rights, these are the foundations of other individual rights.[103] To exercise one's right to life and other basic rights, a person must be alive. This was emphasised in *Makwanyane* case that the right to life precedes all the other rights contained in the Constitution. It would not be possible to exercise rights or to be the bearer of them without life in the sense of existence[104]

In the Constitution, the right to life was deliberately left unqualified. However, the case of *Makwanyane* provided the Constitutional Court with the power to give a clear meaning of what it entails. In spite of the fact that this case dealt with the abolishment of the death penalty, significant interpretations were made about the right to life. Therefore, this research focuses on the interpretation of section 11 of the Constitution, which specifies that all have the right to life. The

94 Shoko *The rights of children* 16.
95 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 2.
96 Section 11 of the *Constitution of the Republic of South Africa*, 1996.
97 Section 10 of the *Constitution of the Republic of South Africa,* 1996.
98 Section 12(2) of the *Constitution of the Republic of South Africa*, 1996.
99 Section 28(2) of the *Constitution of the Republic of South Africa*, 1996.
100 Section 11 of the *Constitution of the Republic of South Africa*, 1996.
101 Venter 2013 *PER* 358.
102 *S v Makwanyane* 1995 3 SA 391 (CC).
103 *S v Makwanyane* 1995 3 SA 391 (CC) para 144.
104 *S v Makwanyane* 1995 3 SA 391 (CC) para 326.

right to life needs to be inclusive of the idea that mature children under the age of 12 years can also exercise this right by refusing to agree to medical treatment or surgical operation as their right to life.[105] This must not be seen as a violation of the right to life, but as a way for mature children to exercise their right to life.

The obligation to support, defend, encourage, and uphold the right to life places the state on both good and bad aspects. The bad aspect of this is that the state cannot impose the death penalty on any citizen because it has to protect the right to life without compromise.[106] Furthermore, self-defence can be perceived as a means of protecting one's right to life.[107] This can be particularly complex, as self-defence in most cases, infringes another person's right to life.[108] The positive aspect of this is that the state protects the lives of its citizens without any hesitation.[109] One could raise the possibility of including children's right to consent to medical treatment without age restriction to the state's duty of promoting and protecting life.

It has become clear that physical existence undoubtedly includes the right to life. In any case, what is the purpose of using the right to life as a physical being if the person is dead or if a life worth living is not worth living? The Constitutional Court in *Makwanyane case*[110] reviewed the right to life. It added that the right to life must impose on the government a duty to create circumstances that enable all people to appreciate a meaningful life.[111]

In case of *Soobramoney v Minister of Health (Kwazulu Natal),*[112] the court dealt with an applicant who was undergoing a chronic kidney failure. *Soobramoney* applied to the court for permission to undergo a dialysis operation because he

105 Venter 2013 *PER* 360.
106 Venter 2013 *PER* 360.
107 Venter 2013 *PER* 361.
108 Venter 2013 *PER* 361.
109 Venter 2013 *PER* 361.
110 *S v Makwanyane* 1995 3 SA 391 (CC).
111 *S v Makwanyane* 1995 3 SA 391 (CC) para 326.
112 *Soobramoney v Minister of Health (KwaZulu Natal)* 1998 1 SA 765 (CC) (hereinafter referred to as the Soobramoney-case).

needed an immediate medical attention. The court rejected the request since the well-being of Soobramoney could not be treated as a plea for immediate treatment.[113] *Soobramoney's* considered his health as being in a direct situation hence the application to the court. Therefore, if a child under the age of 12 was to apply to the court given that he or she is mature enough to comprehend the consequences of the treatment he or she is requesting, would the court have listened to the child's plea? No, because the child is considered to be underage and not mature. This conflicts with the duty of the courts to protect the right to life.

The right to life was also dealt with in the case of *Life healthcare Group v JMS*[114] wherein the parents of an infant child had refused a child to undergo a medical treatment based on their religion. The court held that the right to life is an unavoidable right and that the parent's decision violated the child's right to life.[115] The court further held that the right to life included the right to receive medical treatment, particularly if it is necessary to save the child's life.[116] Therefore, parents should not deny children their right to life, mainly because of their religious beliefs or any other reason. Furthermore, parents should not misuse the right the *Children's Act* [117] provides them, which is to consent on behalf of a child who is under 12 years. Therefore, any child who is under the age of 12 must be permitted to decide on their own what medical treatment would be best suited for them.

The right to dignity and the right to life are inseparable, and are strongly linked. The case of *Stransham-Ford v Minister of Justice and Correctional Services and Others*[118] can be put in the spotlight. The case dealt with the legality of voluntary euthanasia of which is not the focus of this research, and it is important to highlight that, as much as a child has the right to life, the child

113 *Soobramoney v Minister of Health (KwaZulu Natal)* 1998 1 SA 765 (CC) para 21.
114 *Life Healthcare Group (Pty Ltd) v JMS* 2014 JDR 2391 (GJ).
115 *Life Healthcare Group (Pty Ltd) v JMS* 2014 JDR 2391 (GJ) para 13.
116 *Life Healthcare Group (Pty Ltd) v JMS* 2014 JDR 2391 (GJ) para 13.
117 *Children's Act 38* of 2005.
118 *Stransham-Ford v Minister of Justice And Correctional Services and* Others 2015 3 All SA 109 (GP).

also must enjoy a dignified life. In this case, the court held that an individual's standard of living is determined by the Constitution's most important human rights, namely the right to life and dignity.[119] The court considered the applicant's application to have his machines turned off. It then decided that the right to life can not imply that a person has a duty to live, despite the quality of his or her life.[120] Therefore, a child who has lived with cancer since the age of seven can comprehend choosing either to continue or not with chemotherapy can help them preserve their dignity. Parents, guardians or courts should not force competent children below the age of 12 to undergo medical treatment, which result in a life without dignity. Children below the age of 12 are entitled to exercise their right to life. No one is obliged to deny them this right. This is the fundamental right of human rights.

2.4.2 Right to dignity

According to the Constitution on section 10, every citizen's dignity must be protected and respected. The most important human rights are the right to dignity and the right to life. They are inseparable. In the *Makwanyane* case the Constitutional court held that the right to life includes the right to dignity. Human life is limited without dignity. Thus, there can be no dignity without life.[121]

In *Carmichele v Minister of Safety and Security,*[122] human dignity is a crucial aspect which directs the growth for all aspects of law.[123] Human dignity is therefore a right that is legitimate and legally binding. It does not need to be merely respected and protected. All other fundamental rights are interpreted and limited to their significant perspective.[124] When a person acquires socio-economic rights, the right to dignity is recognised. Every child has the right to human dignity. Any person should protect and defend the rights of children. Children should be given the

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119 *Stransham-Ford v Minister of Justice And Correctional Services and Others* 2015 3 All SA 109 (GP) para 23.

120 *Stransham-Ford v Minister of Justice And Correctional Services and Others* 2015 3 All SA 109 (GP) para 23.

121 *S v Makwanyane* 1995 3 SA 391 (CC) para 327.

122 *Carmichele v Minister of Safety and Security* 2001 4 SA 398 (CC).

123 *Carmichele v Minister of Safety and Security* 2001 4 SA 398 (CC) para 56.

124 Venter 2013 *PER* 367.

privilege of enjoying their human dignity right.[125] In addition, the principle of dignity entails that all everyone has the right to enjoy the same equal benefits of society, which goes along with the right to equality.[126] This entails that everyone should be treated equally and fairly.[127]

Moreover, denial of access to basic needs and proper living conditions degrades anyone's human dignity.[128] For this reason, the question that is raised is whether or not a mature child under the age of 12 who is not permitted to consent to medical treatment lives a dignified life. The Constitution outlines the right to human dignity as inherent. Children with maturity skills should therefore be allowed to exercise their rights of choice in medical decisions in order to make independent decisions and protect their dignity.

2.4.3 Right to bodily and psychological integrity

The bodily and psychological integrity entails the right to be left alone and to make choices about a person's body without being meddled with by anybody.[129] Every citizen has the right to bodily and psychological integrity, this is afforded to them by Section 12(2) of the Constitution. It includes the right to make sexual, protection and body health decisions.[130] In addition, without informed consent, one cannot be exposed to scientific or medical tests. [131] This realises the right to self-determination or personal autonomy. Section 12(2) ensures that all persons of any age have the right to personal independence on the basis of their physical and mental honesty.[132] Personal autonomy refers to the freedom of being able to make rational decisions without any interference or limitation.[133] The law has to protect children's rights to integrity the same way it protects that of adults.[134] Section 12(2) of the Constitution

125 Boezaart 2012 *SAPL* 458.
126 Section 28(2) of the *Constitution of the Republic of South Africa*, 1996; Boezaart 2012 *SAPL* 458.
127 Reyneke 2011 *PER* 137.
128 Venter 2013 *PER* 367.
129 Nienaber & Bailey 2016 *SAJBL* 74, Buchner-Eveleigh 2019 *De Jure Law Journal* 245.
130 Section 12(2)(a) -(b) of the *Constitution of the Republic of South Africa*, 1996.
131 Section 12(2)(a) -(b) of the *Constitution of the Republic of South Africa*, 1996.
132 Van der Watt *The child's right to self-determination* 15.
133 Spemars *A critical analyses of South African Mental Health* 75.
134 Van der Watt *The child's right to self-determination* 15.

comprises of three rights, but this research only focuses on the child's right to have security and control over their bodies in making medical treatment decisions.[135] Section 12(2) (b) contains two elements: 'security in' and 'control over' the body of the individual. Security in represents security of one's bodily honesty from any harm inflicted by the state or other parties. "Control over" means one has a right to self-determination without interference.[136] The former is categorised in the sense of being protected from others whereas the latter is categorised under the right to live according to one's desires.[137] Therefore, children above the age of 12 have the right to exercise their right to personal-determination without intervention, and the state must protect the body dignity of children by allowing them to agree to their own medical treatment.

There are no age barriers in the Constitution that allow or deny constitutional rights to anyone. Therefore, all children are entitled to the right to have security and control over their bodies, particularly in making medical choices. In the case of *Christian Lawyers Association v Minister of Health*,[138] the court contended that capacity is closed associated with acquiring the right to give informed consent. It further argued that we differ as people, as there are people above a specific age who are immature and others below the same age or any fixed age who are mature.[139] Maturity levels vary among children. Therefore, a child under the age of 12 who is matured enough should be permitted to exercise his or her right to security and control over his or her body. Furthermore, the privilege to agree to medical treatment should be given to children. Denying children, the right to have security and control over their bodies entails that their right is not respected as it should be. They are, therefore, denied the enjoyment of their right to bodily integrity.

135 Section 12(2)(c) of the *Constitution of the Republic of South Africa*, 1996.
136 Swanepoel 2011 *Obiter* 289.
137 Swanepoel 2011 *Obiter* 289.
138 *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T).
139 *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T) para 20.

2.4.4 The Best Interest of a Child Principle

The principle of the best interest of the child has been applied at common law by courts when making decisions about what would be in the best interest of a child, predominately when children's rights are at risk.[140] Section 28(2) of the Constitution furnish that, in any matter regarding children, it is vital to put the best interest of the child first. According to du Plessis, van der Walt and Govindjee,[141] there is a joint link between sections 28(2) and 28(1)(b) of the Constitution, as well as the definition of care in the *Children's Act*.[142] Section 28(1), (2), and the *Children's Act*[143] guarantee that children's best interest in all matters that affect them is of utmost importance.[144] However, in *Minister for Welfare and Population Development v Fitzpatrick and Others* [145] the Constitutional court had a different view. It held section 28(2) of the Constitution shall be construed as going beyond the rights of Section 28(1) of the Constitution. Furthermore, it is not possible to restrict section 28(2) to the rights set out in section 28(1). Moreover, the court held that, irrespective of those specified in section 28(1) of the Constitution, section 28(2) creates a right.[146]

The Constitutional Court ruled in *Christian Education South Africa v Minister of Education,*[147] that the best interest of a child is a right that all children have. It further held that the idea of the best interests of a child is referred to as a principle.[148] It was therefore uncertain whether a child's best interests should be implemented as an individual right, a principle or a norm.[149]

The Constitutional Court, however, failed to provide explanations as to why it decided that section 28(2) was an individual right. The failure of the court to

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140 Songca 2011 *CILSA* 347.
141 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 15.
142 Section 1 of the Children's Act 38 of 2005.
143 *Children's Act* 38 of 2005.
144 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 15.
145 *Minister for Welfare and Population Development v Fitzpatrick* 2000 3 SA 422 (CC).
146 *Minister for Welfare and Population Development v Fitzpatrick* 2000 3 SA 422 (CC) para17.
147 2000 (4) SA 757 (CC) para 41, Mills 2014 *The South African Law Journal* 857.
148 Mills 2014 *The South African Law Journal* 857.
149 Mills 2014 *The South African Law Journal* 857.

give its judicial explanation for its decision ran a risk of people questioning its predictability, uniformity in application, and certainty.[150]

It opened room for people to think that the best interest of the child principle neglected the rights of children and justified those of parents.[151] In *V v V*,[152] however, the court ruled that the rights of a child are important and have to be secured. Circumstances may occur where the best interest of the child may demand parents to intervene.[153]

The child's best interest are also set out in section 9 of the *Children's Act*.[154] It states that the standard that the best interest of the child is of uppermost significance in all issues relating to the treatment, security and well-being of a child must be applied. Section 7(1) of the *Children's Act* gives a list of factors that will be utilized to deduce the principle of best interest. These factors include, amongst others:[155]

> "The nature of the personal relationship between the child and the parent or caregiver; attitude of the parent towards the child; capacity for provision of the parent; the needs of the child; child's age, maturity, background; the child's emotional, intellectual, social and cultural development; the need for protection of the child, and family violence involving the child or a family member of the child; the practical difficulty and expense of a child having contact with the parents, et cetera."

Upon the adoption of the *Children's Act*,[156] all the factors regarded in the case of *McCall v McCall* were written down.[157] The court relied on those factors provided in *McCall v McCall*[158] whenever it had to deduce the best interest of the child.[159] However, this list of factors was mostly relevant when the court was dealing with custody issues. This led to inconsistencies, since the courts were expected not only to decide the child's best interest in matters of custody

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150 Songca 2011 *CILSA* 347.
151 Currie and De Waal *Bill of Rights Handbook* 619.
152 *V v V* 1998 4 SA 169 (C) 189 B.
153 *V v V* 1998 4 SA 169 (C) 189 B.
154 Section 9 of the *Children's Act*, 38 of 2005.
155 Section 7 of the *Children's Act*.
156 *Children's Act* 38 of 2005.
157 *McCall v McCall* 1994 (3) SA 201 (C).
158 *McCall v McCall* 1994 (3) SA 201 (C).
159 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 16.

but also in issues involving the child.[160] After examining the legislation on child care, the South African Law Commission recommended a list of factors used to deduce a child's best interests.[161] Therefore, due to the inconsistency in the list of factors used in *McCall v McCall*,[162] this led to the inclusion of section 7(1)(a)-(n) in the *Children's Act*.[163]

Although factors provided in section 7(1) of *Children's Act* help courts in giving content to the best interest of the child, Songca, is of the view that the list of factors must be emphasised but should not be considered as a closed one.[164] The courts can take into account other factors that can be used to determine the child's best interest in any specific case.[165] Furthermore, section 7(1) should be read with section 28(2) of the Constitution, which is the source of the yardstick of the child's best interests standard, embodied in section 9 of the *Children's Act*.[166]

The concept of the child's best interests has been elevated to the highest matter in any issue regarding children. Nonetheless, this does not indicate that other constitutional rights must be overlooked or that the best interest of children must at all times reign.[167] In *S v M*,[168] the court considered that the reality that the child's best interests are supreme doesn't quite imply that they are complete. As any other rights found in the Bill of Rights, their application must take into consideration their connection with other rights, which may entail a restriction of their scope.[169]

This meant that just like any other rights, section 28(2) is capable of having limitations.[170] As with any other basic human right, the State has a duty to respect,

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160 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 16.
161 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 16.
162 *McCall v McCall* 1994 (3) SA 201 (C).
163 Du Plessis, Van der Walt and Govindjee 2014 *Obiter* 16.
164 Songca 2011 *CILSA* 348.
165 Songca 2011 *CILSA* 348.
166 Songca 2011 *CILSA* 348.
167 Mills 2014 *The South African Law Journal* 856.
168 *S v M (Centre for Child Law as Amicus Curiae)* 2008 3 SA 232 (CC).
169 *S v M (Centre for Child Law as Amicus Curiae)* 2008 3 SA 232 (CC) para 26.
170 Kruger 2018 *PER* 18.

defend, encourage and uphold this principle.[171] Section 36 of the Constitution may restrict the principle of best interest, and this entails that in the Bill of Rights the principle must be balanced with other rights. In *Hay v B and Others*,[172] an infant was refused the transfusion of blood which he needed to live This was done on the basis that the infant's parents religious beliefs did not allow blood transfusion. The court found the best interests of the child to be of utmost importance when balancing or assessing conflicting rights.[173] Therefore, the child's best interests were upheld. The child was given treatment; thus, the child's right to life was respected.[174] This is an example of balancing competing rights.

Furthermore, the child's right to autonomy rights must be balanced with other fundamental rights. This raises a question of what criteria of the best interest principle ought to be followed wherein the child is afforded a chance to exercise his/her autonomy rights in medical decisions. In *Minister of Welfare & Population Development v Fitzpatrick,*[175] the court considered that the child's best interests principle should be 'flexible' because each case reveals its own circumstances, which would ascertain the best interests of that specific child.[176] Parents of a child under the age of 12, for example, can refuse their child the chance to receive medical treatment only because they believe that such treatment may not have positive results. This is despite the fact that the child may be matured to comprehend the advantages and disadvantages of such treatment. The child, in this instance, is denied his or her autonomy rights in making decisions about what happens to his/her body. Furthermore, the best interest principle would not favour the child's choice but rather that of the parents. Thus, when dealing with similar cases like these, the position of each child needs to be assessed.[177] In addition, the effect of each aspect on the child must be taken into account.[178]

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171 Section 7 of the *Constitution of the Republic of South Africa*, 1996.
172 *Hay v B and Others* 2003 3 SA 492 (W).
173 *Hay v B and Others* 2003 3 SA 492 (W) para 495.
174 *Hay v B and Others* 2003 3 SA 492 (W) para 495.
175 *Minister for Welfare and Population Development v Fitzpatrick* 2000 3 SA 422 (CC).
176 *Minister for Welfare and Population Development v Fitzpatrick* 2000 3 SA 422 (CC) para 428-429.
177 Kruger 2018 *PER* 19.
178 Kruger 2018 *PER* 19.

In *S v M*,[179] the court adopted a procedure that notes that a genuinely compassionate child-centered method involves near and personalised analysis of the particular child's real life condition.[180] A method like this differs from that of the best interest principle. This method, in layman's language states that those children with the requisite maturity must be permitted to take part in their medical choices. It also means refusing a child's choice if he or she is not mature enough to comprehend the danger and implications of medical treatment. Therefore, as children are considered to have evolving capacities, there are possibilities that the provision provided in section 129(2) of the *Children's Act*[181] might not be appropriate in the future. The reason being that children may lose their lives or suffer unnecessarily, whereas they could have been given an opportunity to decide what is best for them.

The rights of the child to autonomy must be weighed with other basic rights. This implies that when a child is assenting to his or her medical treatment, courts must determine every matter on the basis of its individual facts when assessing a child's best interest.

2.4.5 Conclusion

This chapter illustrated that autonomy, competence, and informed consent are closely related. These elements give children the right to have a say on what happens to them provided they have the maturity to comprehend the advantages and disadvantages of the suggested medical treatment. It analysed section 10 of the *Children's Act*,[182] which gives children the right to take part in all issues affecting them. It discovered that section 10 signifies the autonomy right children have in making decisions that affect them. This particularly includes consenting to medical treatment when mature.

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179 *S v M (Centre for Child Law as Amicus Curiae)* 2008 3 SA 232 (CC).
180 *S v M (Centre for Child Law as Amicus Curiae)* 2008 3 SA 232 (CC) para 24.
181 *Children's Act* 38 of 2005.
182 *Children's Act* 38 of 2005.

The chapter further analysed section 129(2) of the *Children's At*,[183] that gives children aged 12 years the legal ability to assent to medical treatment. Children were found to have evolving capacities as they grow; therefore, the use of age in determining children's decision-making capacities makes it difficult to identify children who have acquired maturity before age 12. Moreover, it discussed autonomy rights as afforded in the Constitution. Such included the right to dignity, life, bodily and psychological integrity, and the child's best interest of principle. It found that denying mature children the ability to assent towards their individual medical treatment violates their constitutional rights. Furthermore, section 9 of the *Children's Act*[184] and section 28(2) of the Constitution both provide for the child's best interest principle. Section 7 of the *Children's Act*[185] further provides methods that courts can use when determining what is in the child's best interest. Therefore, upon determining what in medical is in the child's best interest regarding medical decisions, courts need to consider that there exist mature children below the age of 12.

183 *Children's Act* 38 of 2005.
184 *Children's Act* 38 of 2005.
185 *Children's Act* 38 of 2005.

Chapter 3: International Conventions and the position in Canada and United Kingdom regarding children's consent to medical treatment

3.1 Introduction

This chapter reflects on participation rights afforded to children by the United Nations Convention on the Rights of the Child[186] and the African Charter on the Rights and Welfare of the Child.[187] Thereafter, it presents an examination of the legislative and case law position in Canada and the United Kingdom on children's rights to agree to medical treatment. Moreover, the research deduces what South Africa can learn from these jurisdictions. Furthermore, the research concludes with the discussion of alternative methods that can be used to determine the maturity of a child.

3.2 Children's participation rights under international treaties

In non-technical language, the word "participation" is defined as taking part or becoming involved in a particular activity. However, when it comes to the law, participation is defined as having the right to express your opinions freely and to be supported in what you say.[188]

The "participation principle" creates an environment that enables children to contemplate and take action on their own. Furthermore, it encourages adults to value the views of a child. The participation principle promotes acceptance of decisions taken by children, even when it does not favor everyone.[189] Participation is a right. This is also a guiding principle of the CRC and the ACRWC.[190] The CRC and the ACRWC must receive credit because children can freely express their views and opinions without fear of not be taken seriously.[191] Children are regarded as social actors and individuals with rights. CRC has been a building block to promote

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186 United Nations Convention on the Rights of the Child (1989) (hereinafter referred to as the (CRC).

187 African Charter on the Rights and Welfare of the Child (1990) (hereinafter referred to as the ACRWC).

188 Viviers and Lombard 2012 *International Social Work* 11.

189 Boniface 2013 *Speculum Juris* 131.

190 Henderson, Pendlebury and Tisdall 2011 *Perspectives in Education* 1.

191 O'Kane and Ravi 2007 *Children, Youth and Environments* 138.

the principle of children's participation.[192] The right of children to take part symbolises a social shift, which brings about the question of what the children in society can afford.[193]

The South African government ratified the CRC[194] in 1995 and the ACRWC[195] in 2000. Therefore, it is bound to actualise children's participation rights as provided by the CRC and the ACRWC.[196]

3.2.1 United Nations Convention on the Rights of the Child (CRC)[197]

Article 12 of CRC articulates that every nation has the obligation to allow all children able of formulating their own views, the legal ability to communicate those views openly in issues that affect them. Furthermore, consideration must be provided to the views of children, in observance of their maturity and age.[198]

As provided for in Article 12(1) of the CRC, Member States must make certain that children who are able to partake have a chance to do so without interference.[199] Such children should be allowed to voice their interests openly without any constraint or interference on their parents or anyone else associated with them.[200] According to Kruger,[201] the phrase of being able to formulate a view confers on the state the duty for requiring all mature children to voice their opinions.[202]

Article 12 has no boundaries on the age of children to exercise their right to participate.[203] Therefore, every child who can voice his or her interest has a legal ability to participate regardless of their age and maturity.[204] The Committee of Rights of the Child[205] provides that the significance of a child's views is not

192 O'Kane and Ravi 2007 *Children, Youth and Environments* 138.
193 O'Kane and Ravi 2007 *Children, Youth and Environments* 138.
194 United Nations Convention on the Rights of the Child (1989).
195 African Charter on the Rights and Welfare of the Child (1990).
196 Bray and Moses 2011 *Perspectives in Education* 7.
197 United Nations Convention on the Rights of the Child (1989).
198 Article 12(1) of the United Nations Convention on the Rights of the Child (1989).
199 Moyo 2015 *SAJHR* 174.
200 Moyo 2015 *SAJHR* 175.
201 Kruger, 2018 *SALR* 77.
202 Kruger, 2018 *SALR* 77.
203 Lansdown 2001 *UNICEF* 2.
204 Moyo 2015 *SAJHR* 176.
205 *Committee on the Rights of the Child General Comment No 12: The Right of the Child to be Heard* (CRC/C/GC/12 20 July 2009); Kruger 2018 *PER* 14.

determined by age only. Furthermore, the Committee suggests independent review of children's views.[206] This is because many different factors can play an important role in building a child's ability to formulate a view. Factors that can contribute to the maturity of a child are; data, knowledge, environment, expectations of society and culture and support rates.[207]

Article 12 further provides that the interests of the child must be regarded as important, if he or she understands the nature of the matter at hand.[208] Therefore, this entails that parents and courts must listen to the children's views and consider them.[209] Moreover, a meeting needs to be conducted after gathering the views of the child to determine how this influences the results of the procedure.[210] Article 12 also provides that children who can formulate and express their views should be allowed to do so in medical treatment decisions.[211] The *Children's Act*[212] affords children above the age of 12 to express their views when a medical treatment decision needs to be taken. It is submitted that the *Children's Act*[213] violates article 12 of the CRC, as it does not make room for mature children below the age of 12 to express their views when a decision needs to be taken.

3.2.2 African Charter on the Rights and Welfare of the Child (ACRWC)[214]

The ACRWC affords the right of children to participate protection. Article 4(2) of the ACRWC states that every child who is able to communicate his or her own thoughts should have the opportunity to voice his or her views personally or through a representative in a court proceeding.[215] The relevant authority shall take these views into account in compliance with the rules of the law.[216]

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206 *Committee on the Rights of the Child General Comment No 12: The Right of the Child to be Heard* (CRC/C/GC/12 20 July 2009); Kruger 2018 *PER* 14.
207 Kruger 2018 *PER* 14.
208 Lansdown 2001 *UNICEF* 2.
209 Kruger, 2018 *SALR* 78.
210 Kruger, 2018 *SALR* 78.
211 Kruger, 2018 *SALR* 78.
212 *Children's Act* 38 of 2005.
213 *Children's Act* 38 of 2005.
214 African Charter on the Rights and Welfare of the Child (1990).
215 Article 4(2) of the African Charter on the Rights and Welfare of the Child (1990).
216 Article 4(2) of the African Charter on the Rights and Welfare of the Child (1990).

Article 4(2) is read together with article 7, which states that any child able to express his or her views shall be guaranteed the right to express them. Their opinions are subjected to restrictions as prescribed by laws.[217]

ACRWC and CRC require the participation of children who are able to express their perspectives. However, CRC emphasises the age and maturity of children. Therefore, it can be concluded that the ACRWC gives children of any age group the legal ability to voice their perspectives in medical treatment because they have demonstrated a precise maturity level.[218]

The provision in the ACRWC, which provides that the perspectives of children will be assessed in compliance with the rules of an appropriate law, is seen as a setback clause.[219] This means that the state has a choice to limit this right. Furthermore, the ACRWC restricts children's participation in administrative and court proceedings.[220] The CRC, on the contrary, allows children to openly express their perspectives, provided they can formulate them.[221] This, therefore, shows that the CRC provides resilient security other than the African Charter.[222]

Lastly, the provision that states that children be given the opportunity to voice their views personally or through a representative, refers to the child as being an effective party in the proceedings.[223]

Therefore, consenting to medical treatment is considered as part of matters that affect children. Both article 12 and 4(2) of the CRC and ACRWC support children who can form or communicate matured views to assent to their medical treatment. Therefore, the 12-year age requirement in the *Children's Act* does not follow the two participation articles stipulated in both the CRC and the ACRWC.[224] It is submitted that South African courts need to allow children who show abilities to

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217 Article 7 of the African Charter on the Rights and Welfare of the Child (1990).
218 Kruger 2018 *PER* 16.
219 Kruger 2018 *SALR* 81.
220 Kruger 2018 *SALR* 81.
221 Kruger 2018 *SALR* 81.
222 Kruger 2018 *SALR* 81.
223 Kruger 2018 *SALR* 81.
224 Kruger 2018 SALR 93.

form or communicate a matured view to take part in medical treatment decisions that affect them, irrespective of their age.

3.3 Canada

As in any other jurisdiction, Canada has laws regarding children's assent to medical treatment. This section discusses Canada's legislation and case law that deals with children's assent to medical treatment. Furthermore, the section presents how South Africa can amend its current legislation.

According to the British Columbian law, the *Infants Act*[225] permits children to agree to their individual medical treatment if they understand the benefits and dangers of the treatment.[226] Approval from a parent is not required once a child has provided his or her assent.[227] Furthermore, in New Brunswick, the *Medical Consent of Minors Act*[228] indicates laws governing assent to medical treatment which applies to children who are 16 years and older.[229] However, in certain circumstances, the Act provides for assent of children under the age of 16. These circumstances are provided in section 3(1) of the *Medical Consent of Minors Act*.[230] Section 3(1) provides that children below the age of 16 can agree to medical treatment if they understand the benefits and implications of the proposed treatment.[231]

Moreover, in Ontario, the *Health Care Consent Act*,[232] makes provision for children with capabilities to agree to medical treatment. Section 4(a) of the *Health Care Consent Act* stipulates that anyone (including children) who is able to comprehend the dangers and gains of the proposed treatment can agree to such treatment.[233]

In the case of in *AC v Manitoba*,[234] a girl at the age of 14 who was experiencing lower gastrointestinal bleeding, refused medical treatment. The reason for refusing

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225 Chapter 223, Section 17 of the *Infants Act* (RSBC 1996).
226 Chapter 223, Section 17 of the *Infants Act* (RSBC 1996).
227 Chapter 223, Section 17 of the *Infants Act* (RSBC 1996).
228 Chapter 223, Section 17 of the *Infants Act* (RSBC 1996).
229 Section 2 of the *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1.
230 *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1.
231 Section 3(1) of the *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1.
232 *Health Care Consent Act*, 1996.
233 Section 4(a) of the *Health Care Consent Act*, 1996.
234 *AC v Manitoba (Director of Child and Family Services)* (2009) SCC 30.

was that, the proposed treatment was in contradiction with her religious beliefs. The court decided that it was best for children below the age of 16 to lead evidence in order for it to assess their maturity.[235] It further held that this evidence must be enough to determine their ability to make treatment decisions.[236]

The maturity of a child, in this case, was not assessed based on age but rather on maturity. The criterion that the court used in this case is called the 'mature minor doctrine'.[237] This doctrine acknowledges that some children can be mature enough to make their individual medical decisions.[238] Furthermore, it states that minors, irrespective of their age who can demonstrate adequate maturity, should be given the power to make self-reliant choices without any influence from a third party.[239] This doctrine is the same as the common law rule, which recognises that children are able to agree to medical treatment irrespective of their age.[240]

The legislations provided above, as well as the mature minor doctrine adopted in the case of *A.C. v. Manitoba* all agree on the same thing. All of them permit children to assent to their medical treatment regardless of their age. A child must show the capability of understanding the dangers and benefits of the treatment. The ability to assent to treatment is based on maturity and not age. In South Africa, a child has to be 12 years and above to be able decide what kind of medical treatment is best suited for them.[241] Furthermore, the child has to have the qualities of comprehending the benefits and dangers of the treatment.[242] The *Children's Act*[243] provides no opportunities for those who are below the age of 12 but are mature to give consent. Therefore, South Africa courts should adopt the criteria used by the three-legislations discussed above, as well as the mature minor doctrine. This enables the *Children's Act*[244] to make provision for children who are below the age

235 *A.C. v. Manitoba* (Director of Child and Family Services) 2009 SCC 30 para 112.
236 *A.C. v. Manitoba* (Director of Child and Family Services) 2009 SCC 30 para 111.
237 O'Connor 2009 *The Journal of Lancaster General Hospital* 63.
238 O'Connor 2009 *The Journal of Lancaster General Hospital* 63.
239 Jonathan 2006 *J. Contemp. Health L. & Pol'y* 236.
240 Harrison, Kenny, Sidarous and Rowell 1997 *Canadian Medical Association* 826.
241 Section 129(2)(a) of the *Children's Act* 38 of 2005.
242 Section 129(2)(b) of the *Children's Act* 38 of 2005.
243 *Children's Act* 38 of 2005.
244 *Children's Act* 38 of 2005.

of 12 but have the abilities to comprehend the dangers and gains required to agree to their treatment.

3.4 United Kingdom

In the United Kingdom, there is a principle called the *Gillick* competence principle. This principle is taken from the English case of *Gillick v West Norfolk and Wisbech Area Health Authority*.[245] This principle is the same as the mature minor doctrine discussed above. The principle of *Gillick* competence is not used under South African law. However, most jurisdictions have adopted this principle into their laws.

In the case of *Gillick*, the Department of Health and Social Security issued a circular directed to doctors. It instructed doctors at health clinics that if girls younger than 16 years, seeking contraceptives consult them, they should issue to them upon their request.[246] It further stated that doctors would be acting lawfully if they prescribe pregnancy control tools to younger girls below 16 years. Moreover, it provided that the doctors doing so would be acting in a proper manner to shield the girls from the negative effects of sexual activities.[247] In addition, doctors were allowed to give pregnancy control tools to girls below 16 years of age without first consulting their parents. It stated that the doctor should abide by the principle of doctor and patient confidentiality and not contact the parents without the child's consent.[248]

The main aim of *Gillick* case was to clarify whether a doctor is authorised by the law to prescribe and give advice on pregnancy control tools to a girl below 16 years of age.[249] Lord Scarman held that children who are under the age of 16 years could give assent provided they have the intelligence and understanding of the treatment that is being proposed.[250] The case of *Gillick* introduced the idea of a '*Gillick competent child*'. Therefore, a child is *Gillick* competent if he or she has the intelligence and maturity to understand the proposed treatment fully. There is no

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245 *Gillick v West Norfolk and Wisbech Area Health Authority and another* [1986] 1 AC 112 (HL) (herein after referred to as the *Gillick* case).

246 *Gillick* case para 1.

247 *Gillick* case para 1.

248 *Gillick* case para 1.

249 McLean 2003 *VUWLR* 556.

250 Trowse 2010 QUTLJJ 206.

fixed age attached to this legal principle.[251] The parental right to consent is no longer applicable when the child achieves this competence.[252] A *Gillick* competent child has the maturity and abilities to weigh up a decision he or she wants to make. Therefore, any decision taken by a *Gillick* competent child needs to be valued. The violation of bodily integrity and self-determinations of the *Gillick* competent child is caused by anyone who dishonours the decision by the child based on someone's views.[253]

The determination factor of *Gillick* competence depends on the child's maturity capacity. A Gillick competent child's maturity and intelligence must be cross-examined and approved. This affirms that the child is competent.[254] Furthermore, the child must receive a clear explanation of the treatment from health professionals. A *Gillick* competent child must not only be matured and intelligent but also, have a full understanding of the information provided to him or her regarding the medical treatment. Moreover, the child must also be able to answer questions asked pertaining to the treatment.[255]

In *Re L*,[256] the court ruled that irrespective of the fact that the 14-year-old girl was found to be mature, she was, however, not *Gillick* competent. This resulted from failure of medical staff to have a formal meeting with the girl to explain the important information regarding the treatment. She was not advised that if she refuses to give assent to treatment, she would suffer a horrible death.[257] The court, however, held that although the child possessed the ability to understand what a horrible death meant, it was not enough because she did not receive a formal meeting where the advantages and disadvantages of the proposed medical treatment were explained.[258]

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251 Trowse 2010 *QUTLJJ* 206.
252 Alderson 2007 *Social Science & Medicine* 2273.
253 Trowse 2010 *QUTLJJ* 205.
254 Trowse *2010 QUTLJJ* 207.
255 Trowse 2010 *QUTLJJ* 207.
256 *Re L* [1998] 2 *FLR* 810.
257 *Re L* [1998] 2 *FLR* 810 para 813.
258 *Re L* [1998] 2 *FLR* 810 para 813.

Therefore, a Gillick competent child is not only mature and intelligent but also adequately informed about the proposed medical treatment.[259] Moreover, for a child to be able to assent to medical treatment, he or she has to possess the qualities of a Gillick competent child. Such a child must have the capabilities of comprehending the treatment he or she wants to assent to. Furthermore, the child has to be advised about the nature of the treatment and questioned to determine if he/she understands what the treatment entails.

The Gillick competence principle does not have a fixed age for children to assent to medical treatment. It is the same as the mature minor doctrine, because both principles rely on the maturity of the child. South African courts do not cross-examine the capability of a child as the Gillick competence principle does. To avoid implications, it is proposed that the South African court should adapt the Gillick competence principle to allow matured children to assent to medical treatment.

3.5 Methods to determine children's maturity

In South African, currently courts have not clarified what the sufficient maturity in the *Children's Act*[260] requires from a child.[261] The *Children's Act*[262] does not provide any guidelines or regulations on how to assess the maturity of a child.[263] Developing method(s) to determine a child's maturity would help the courts and health care professionals in dealing with cases of children who want assent to medical treatment.

When assessing the maturity of a child, health care professionals must provide detailed information on the treatment. They must also give the child time to articulate their concerns. Furthermore, they have to assess the child's capability of comprehending the dangers and benefits of the suggested treatment.[264] The court and health professionals can perform a further assessment by enquiring about a child's life experiences pertaining to the treatment. A child's capacity is highly

259 Trowse 2010 *QUTLJJ* 208.
260 *Children's Act* 38 of 2005.
261 Havenga and Temane 2016 *South African Family Practice* 44.
262 *Children's Act* 38 of 2005.
263 Jamieson and Lake 2013 *Children's Institute* 44.
264 Jamieson and Lake 2013 *Children's Institute* 44.

dependent on their life experiences. Once bitten, twice shy, children who have experienced any medical treatment more than once possess an in-depth understanding of how their decisions affect them.[265]

When interrogating the child's decision on medical treatment, courts and health care professionals must use a language that is well understood by the child.[266]

The adoption of the above-mentioned methods would enable children under 12 years to be given a chance to decide on the medical treatment they want without any assistance from a guardian or parent.

3.6 Conclusion

The CRC and the ACRWC afford children the right to participate in medical treatment decisions. If the government fails to permit children to formulate and voice their perspectives in medical treatment, this renders the state acting against its obligations. This chapter outlined two approaches that support children under the age of 12 who want to assent to the medical treatment that is best suited for them. These are the mature minor and the *Gillick* competence principle. These approaches require that a child should have the abilities to comprehend the suggested treatment. The child has to show the qualities of understanding the dangers and benefits of the treatment he or she wants to undergo. Although these approaches are based in foreign jurisdictions, they can serve as guidelines for the South African courts in determining the competence of children below the age of 12.

265 Jamieson and Lake 2013 *Children's Institute* 44.

266 Du Preez *The Medical Treatment of Children* 2011.

Chapter 4: Conclusions and Recommendations

4.1 Introduction

Children's right to consent to medical treatment has long been recognised under the South African law. It began with the *Child Care Act*,[267] where children at the age of 14 years and above were regarded as individuals who are qualified to agree to medical treatment.[268] Parental assistance was not required in this instance. New developments and discoveries were later made. The *Child Care Act*[269] was repealed by the *Children's Act*.[270] According to section 129(2) of the *Children's Act*, children over 12 years can now agree to medical treatment which is suited for them. This is on the basis that they understand the dangers and gains of the medical treatment, and also, they must show adequate maturity. Therefore, a child must be 12 years old or above and competent to consent to a medical treatment. However, there are loopholes with regards to children under 12 years of age consenting to their medical treatment.

It is worth noting that children have autonomy rights. These autonomy rights entitle them to make independent decisions without their parent's approval. There is no prescribed age for children to exercise their autonomy rights. However, children are challenged when they need to exercise their autonomy in medical treatment decisions.

As captured in the problem statement, the central question in this research is whether the presumption/provision in section 129(2) of *Children's Act,* which states that children who are under 12 years do not have the necessary ability to decide on medical treatment, prevent them from exercising their autonomy rights in medical treatment decisions? The study aimed to argue that the abilities of children being part of making decisions regarding medical treatment should not depend on age

267 *Child Care Act* 74 of 1983.
268 Section 39(4) (b) of the *Child Care Act* 74 of 1983.
269 *Child Care Act* 74 of 1983.
270 *Children's Act* 38 of 2005.

but rather on maturity. The reason was that there are children who mature before reaching the age of 12 years.

4.2 Findings of the study

Section 10 of the *Children's Act*[271] affords children the right to take part in all matters that affect them. Section 10 does not stipulate a specific age requirement for children to participate. This implies that children of all years are entitled to take part in decisions that affect them, most importantly, the right to agree to medical treatment. The CRC and ACRWC further affords all children capable of forming or communicating their perspectives, the right to express them. However, not all children are afforded the right to take part in issues that affect them. This is attributable to section 129(2) of the *Children's Act*,[272] as it only allows children who are 12 years and above and are matured enough to assent to their individual medical treatment. The *Children's Act*[273] considers children under 12 years as lacking the necessary ability to agree to medical treatment. It fails to take into account that some children younger than 12 years might be matured enough give assent to medical treatment. Moreover, the Act[274] fails to clarify what it means by 'sufficient maturity' or how it measures it. Thus, two similar approaches from Canada and the United Kingdom were discussed as lessons to be adopted by South Africa.

The first approach is called the mature minor doctrine. According to this doctrine, minors, irrespective of their age, who can demonstrate sufficient level of maturity and comprehend the dangers and benefits of the proposed medical treatment, are given the power to make independent decisions without any influence from a third party. The maturity of a child, in this case is assessed based his or her maturity and not age.

The second approach is called the Gillick competence principle. This principle, allows children to give assent to medical treatment provided they have the intelligence,

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271 *Children's Act* 38 of 2005.
272 *Children's Act* 38 of 2005.
273 *Children's Act* 38 of 2005.
274 *Children's Act* 38 of 2005.

maturity, and understanding of how the treatment affects them. Such a child with those capabilities is a Gillick competent child. There is also no age requirement in this principle. A Gillick competent child has the maturity and abilities to evaluate medical decisions. The decisions taken by a Gillick competent child should therefore be respected.

The research further discovered that the constitutional rights of children younger than 12 years are infringed when they are denied the right to assent to their individual medical treatment. Such rights include, the right to life, dignity, and bodily and psychological integrity. Furthermore, it discovered that the courts must assess each case on its individual merits when deducing the child's best interest in medical treatment decisions.

4.3 Recommendations

It is recommended that two approaches that determine the maturity of children to agree to medical treatment should be adopted by the *Children's Act*.[275] These approaches are the Gillick competence principle and the mature minor doctrine. In doing so, children below the age of 12 would be given an opportunity to be assessed. If they are found to be mature enough to comprehend the dangers and benefits of the proposed medical treatment, they should be allowed to give consent irrespective of their age. Parents also ought not to interfere with the decision of such a child. Thus, the child will be exercising their autonomy rights.

The *Children's Act* does not stipulate what it means by 'sufficient maturity' in section 129(2). The courts need to find methods that can be used to assess the maturity of the child. Methods that are recommended in this research are; providing the child with detailed facts concerning the treatment the child wants to consent to, followed by asking the child questions using the language the child understands to assess if he or she comprehends the dangers and benefits of the proposed treatment.

275 *Children's Act* 38 of 2005.

The last recommendation involves the amendment of section 129 (2) of the *Children's Act*[276] to accommodate children younger than 12 years to give assent to medical treatment. The *Children's Act*[277] should do away with the age restriction and focus mainly on the adequate maturity of children and their ability to comprehend the dangers and benefits of the medical treatment.

4.4 Conclusion

The research has revealed that the *Children's Act*[278] unfairly excludes children below the age of 12. This is done by not considering their maturity assent to medical treatment. In conclusion, children younger than 12 years should be given the right assent if they have adequate maturity to comprehend the dangers and benefits of the medical treatment.

276 *Children's Act* 38 of 2005.
277 *Children's Act* 38 of 2005.
278 *Children's Act* 38 of 2005.

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