# *The Medical Treatment of Children and the Children's Act 38 of 2005*

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# PREFACE

I should like to express my heartfelt gratitude to the following persons:

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Willie Du Preez

# SUMMARY

During the last decade a considerable number of statutes were adapted in South Africa pertaining to the medical treatment of children. Following international norms regarding this matter, South African law also prescribes a minimum age of consent for children seeking medical treatment without the parent's or guardian's consent.

The long awaited Children's Act revolutionised child law in South Africa in that it is a piece of legislation touching on a wide spectrum of issues which impact on children's lives. Before the Children's Act, matters regarding children were found in scattered fragments in a number of Acts and were not always focused on the child. The Act was hailed by children's rights activists and generally welcomed. However, as with all legislation, the Act is not without its shortcoming and there are several areas which are vulnerable to criticism.

In any communication or transfer of information, the manner in which the message or information is constructed will influence the ultimate decision. The Act does not address the manner or mode in which information is conveyed to the child. For instance, it does not address the predisposition that the medical practitioner consulting the child may have, nor does it require an impartial medical practitioner to assist the child in his/her assessment and decision in the matter. In this regard, the caution offered by Du Preez may be applicable, that "*if the effective meaning of the information predominates over the conceptual meaning thereof, the listener/ reader will fail to make a proper judgement of what is being said.*"[1]

Section 129 does not contain any guidelines or provisions on how a medical practitioner should test whether a child has the mental capacity to understand the information regarding the proposed treatment. The study will report on the results of a consultation with a counselling and educational psychologist to determine which tests or methods could be used by medical practitioners to evaluate the maturity of child patients and the implications this could have on the child and his/her medical treatment. The prerequisites as set out in the new Children's Act will be examined and the possible problems which might occur will be discussed.

[1] Du Preez (1986) *'n Strategie vir Beeldpropaganda in die Suid-Afrikaanse Departement van Buitenlandse Sake* (MA in communications thesis 1986 UNISA) 19.

# Table of Contents

# Chapter 1: Introduction

During the last decade a considerable number of statutes were adapted in South Africa pertaining to the medical treatment of children. Following international norms regarding this matter, South African law also prescribes a minimum age of consent for children seeking medical treatment without the parent's or guardian's consent.

Internationally there is pressure on lawmakers to decrease the minimum age of consent for children when it comes to medical treatment to bring it in line with international trends. Other factors that play a role in this argument are issues such as child-headed households and orphans. These factors are specifically relevant in African countries, where children lose their parents due to continued conflict on the continent, Malaria, TB and HIV/AIDS.

In South Africa, law reform in line with international trends towards lowering the age began in 1991 with the Child Care Amendment Act[2] which decreased the lawful age of consent for the medical treatment of children, as prescribed by the Child Care Act,[3] from eighteen years to fourteen years of age. After 1 July 2007 the position was changed considerably with the commencement of the new Children's Act.[4]

Before the Children's Act came into force, the rules and prerequisites regarding consent for the medical treatment of children were prescribed by a number of separate statutes such as the Child Care Act,[5] the National Health Act,[6] the Choice on Termination of Pregnancy Act[7] and the Sterilisation Act.[8]

The issues surrounding consent, according to South African law as set out in statute, the common law and case law will be highlighted. I will also be looking at the prerequisites regarding consent for the medical treatment of children in statutes leading up to the

[2]Act 86 of 1991.

[3]Act 74 of 1983.

[4]Act 38 of 2005.

[5]Act 74 of 1983. This act was repealed by the Children's Act 38 of 2005

[6]Act 61 of 2003.

[7]Act 92 of 1996.

[8]Act 44 of 1998.

Children's Act[9] and how South African and international case law contributed to the development of a system that granted more autonomy to children.

The long awaited Children's Act revolutionised child law in South Africa in that it is a piece of legislation touching on a wide spectrum of issues which impacts on children's lives. Before the Children's Act, matters regarding children were found in scattered fragments in a number of Acts and were not always focused primarily on the interest of the child. The Act was hailed by children's rights activists and generally welcomed. However, as with all legislation,the Actis not without fault and there are several areas which are vulnerable to criticism.

The main focus of this study will be the medical treatment of the child and more specifically section 129 of the Children's Act. Broadly summarised, section 129 states that a child may consent to his/her own medical treatment without the parent when the child is over the age of twelve and possesses the necessary mental capacity to understand the treatment, all the pros and cons of the treatment, as well as all the implications of his/her decision.

In a country which has one of the highest HIV/AIDS infection rates in the world,[10] this section provided relief. With the ever increasing number of orphans and child-headed households it is sometimes almost impossible to find a care-giver or foster parent with the authority to assist such an orphan when he/she needs medical treatment. With the introduction of section 129 the parent's authority is no longer required for children older than twelve years, and as a result access to much-needed medical treatment is now available to more children.

However, the lack of regulations, definitions and sufficient description in the section leaves it susceptible to risk of failure in implementation. Section 129 is based on the child's mental

[9] 38 of 2005; hereinafter "the Children's Act".

[10] See 'Impact of HIV upon South Africa' available at http://www.avert.org/aidssouthafrica.htmaccessed on 9 December 2011, where it states that: *"An estimated 40,000 children in South Africa are infected with HIV each year, reflecting poor prevention of mother-to-child transmission (PMTCT). AIDS is one of the main contributors to South Africa's infant mortality rate, which increased significantly between 1990 (44 deaths per 1000 infants) and 2008 (48 per 1000), when all regions of the world saw decreases. Around 30% of pregnant women in South Africa's 2009 National Antenatal Survey were HIV positive, demonstrating the need for South Africa to deliver effective PMTCT programs*."

capacity and informed consent. When a medical practitioner consults his underage patient on medical treatment the child will have to base his/her decision on the following factors:

- The advantages and disadvantages of the treatment.
- The possible negative effects of the treatment.
- Alternative treatment available and their effects.
- The implications if the patient refuses to have treatment.

The medical practitioner relays the above information to the child and the child has to make a decision based on the information supplied.

As in the case in any communication or transfer of information, the manner in which the message or information is constructed will influence the ultimate decision.The Act does not address the manner or mode in which the information is conveyed to the child. For instance, it does not address the predisposition that the medical practitioner consulting the child may have, nor does it require an impartial medical practitioner to assist the child in his/her assessment and decision in the matter. In this regard, the caution offered by Du Preez may be applicable, that "*if the effective meaning of the information predominates over the conceptual meaning thereof, the child will fail to make a proper judgement of what is being said.*"[11]

As section 129 does not contain any guidelines or provisions on how a medical practitioner should test whether a child has the mental capacity to understand the treatment, the study will report the results of a consultation with a counselling and educational psychologist to determine which tests or methods should be used by medical practitioners to evaluate the child patients. The implications this could have on the child and his/her medical treatment will also be investigated. The prerequisites as set out in the new Children's Act will be examined and the possible problems which might occur will be discussed. The arguments for and against these new measurers will then be set out.

[11]Du Preez (1986) *'n StrategievirBeeldpropaganda in die Suid-AfrikaanseDepartement van Buitenlandse Sake* (MA in communications thesis 1986 UNISA) 19.

# Chapter 2: Past and Present Legislation

## 2.1 Introduction

To get to a better understanding of how the relevant sections of the Children's Act came about, one has to consider some of the legislation that pre-dated it and how the rights of children in regard to medical treatment in South African evolved over the past decades. All of the statutes contributed in some way to what would be included in South Africa's first comprehensive piece of child-related legislation, which deals with a wide range of matters pertaining to children in this country. Aselection of cases which had a profound impact with regard to children's rights and health carewill be highlighted.

## 2.2 The Child Care Act 75 of 1983

The Child Care Act[12] determined that a child above the age of fourteen may give consent to his or her own medical treatment without the assistance of the parents or guardian. Furthermore, an 18 year oldcould give consent to any surgical procedure without the consent or assistance of his or her parent.[13]

It should be noted that this Act did not require any test of maturity. . Although there were some guiding principles within the common law to protect children and enforce some form of control over this aspect, they were not as extensive as those later introduced by the Children's Act.[14]Only later when the National Health Act[15] came into play, was it clearly stated that medical personnel should certify that the patient fully understands all information regarding the proposed treatment.

## 2.3 The Constitution of the Republic of South Africa 1996

On 1 February 1996, the 1993 Interim Constitution [16] was replaced by the final Constitution[17]which launched the country into becoming aconstitutional democracy for the

[12] This Act was repealed by the Children's Act.

[13] S 39(4)(a).

[14] See 3.1 below.

[15]Act 61 of 2003.

[16]Act 200 of 1993.

first time. Section 2 affirms that the Constitution is the supreme law of the country.[18]Aligning South Africa with international trends and norms, the Constitution also includes a Bill of Rights in Chapter 2. Chapter 2 is best described in section 7 which states:

> *"(1) This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom.*
>
> *(2) The state must respect, protect, promote and fulfil the rights in the Bill of Rights.*
>
> *(3) The rights in the Bill of Rights are subject to the limitations contained or referred to in section 36, or elsewhere in the Bill."*

Chapter 2 binds all organs of state, including the legislative, executive and judiciary.[19]Section 28 of the Constitution, deals exclusively with the rights of children in South Africa, amongst them is the right to health care.[20]It should be noted that section 27 of the Constitution already affirms this right to all persons, but section 28 specifically has children in mind. In addition to the right to health care, the Constitution also predetermines that the best interest of the child is of paramount importance regarding all matterspertaining to the child.[21]

## 2.4 The Choice on Termination of Pregnancy Act 92 of 1996

When it comes to children's consent to medical treatment, this Act differs from those discussed thus far. The Act states in section 1 that for purposes of this Act that 'a woman' is a female person of any age. The effect of this is that the age threshold prescribed by the Child Care Act[22]is not applicable to a child-patient when that patient is a girl who wants her pregnancy terminated.

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[17]Constitution of the Republic of South Africa, 1996 (hereinafter "the Constitution" or "the final Constitution".

[18] "This Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled."

[19]S 8.

[20] S 28(1)(c) of the Constitution.

[21]S 28(2) of the Constitution.

[22]75 of 1983.

This Act goes even further in that no parental consent or even parentalassistanceisrequired whenafemale childwants her pregnancy terminated. The only time that consent would be required by a third person, would be when the female child is mentally unable to comprehend the implications or extent of the procedures, or when she is in a state of continuous unconsciousness and there is no reasonable expectationthat she will regain consciousness in time to request and consent to the termination of her pregnancy.[23]The Act also protects the identity of the patient in that it prohibits the disclosure of the patient's identity, unless the patient discloses it of her own accord.[24]

The Choice on Termination of Pregnancy Act has no regulations as prescribed in the National Health Act[25] or the Child Care Act, with regards to the age or maturity of a female patient seeking to terminate the pregnancy.[26]This may lead to ethical and moral implications for medical practitioners as some medical practitioners may be opposed to the termination of pregnancy due to religion or other similar views.

## 2.5 The Constitutional Test

In 2004 the Choice on Termination of Pregnancy Act[27]was constitutionally challenged in the case of *Christian Lawyers' Associationv National Minister of Health and Others.*[28]The applicant brought the case seeking to have subsections 5(2) and 5(3) read with the definition of 'a female' declared unconstitutional. Section 1 refers to 'a female' of any age.

It was argued that this section was unconstitutional because it allows a female under the age of 18 to have her pregnancy terminated without parental consent or assistance.It was argued that a minor female was not in the position to decide by herself and on her own to end a pregnancy and that her parents played a crucial role in this major medical decision.

[23]S 5.

[24]S 7.

[25]Act 61 of 2003.

[26]Act 75 of 1983.

[27]Act 92 of 1996.

[28]2004 10 BCLR 1086 (T).

It was further argued that this Act[29]was in conflict with sections 28(1)(b),[30]28(1)(d)[31] and 9(1)[32] of the Constitution. The court did not agree, as the applicant did not provide adequate grounds.The court came to this conclusion with the support of section 12(2) of the Constitution.[33]Section 12(2) guarantees a female's right to bodily integrity. This includes the right to participate in all reproductive matters concerning her body. The Constitution affords these rights to all in South Africa and the court thus came to the conclusion that this would include the right of a female to decide the outcome of her own pregnancy.

In addition to section 12(2), the court also cited that the rights to not be discriminated against on basis of gender, right to privacy.[34]

It should be noted that the Choice on Termination of Pregnancy Act is expressly excluded from the Children's Actin section 129(1) which reads as follows:

> *"Subject to section 5(2)[35] of the Choice on Termination of Pregnancy Act, 1996(Act No. 92 of 1996), a child may be subjected to medical treatment or a surgical operation only if consent for such treatment or operation has been given in terms of either subsection (2), (3), (4), (3), (6) or (7)."*

Therefore female children who opt to have their pregnancy terminated would fall outside the protection of the Children's Act.

## 2.6 The Sterilisation Act 44 of 1998

[29]Choice on Termination of Pregnancy Act 92 of 1996.

[30]*"Every child has the right- to family care or parental care, or to appropriate alternative care when removed from the family environment*."

[31]*"Every child has the right- to be protected from maltreatment, neglect, abuse or degradation*."

[32]*"Everyone is equal before the law and has the right to equal protection and benefits of the law*."

[33]*"Everyone has the right to bodily and psychological integrity, which includes the right – (a) to make decisions concerning reproduction; (b) to security in and control over their body: and (c) not to be subjected to medical or scientific experiments without their informed consent."*

[34]S 9(3) and S 14 of the Constitution.

[35]S 5 (2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.

In term of the Sterilisation Act, a person may only be sterilised if they are above the age of 18 and have given expressed permission.[36]This means that a child under the age of 18 may not be sterilised unless it can be proven that failure to do so would lead to detrimental health risks to the child andif no other safe or effective means of contraception is available.[37] To determine if these factors are present the Act prescribes that a panel is assembled to make these assessments. The panel consists of:(a) a psychiatrist or a medical practitioner if no psychiatrist is available; (b) a psychologist or a social worker; and (c) a nurse.[38]

The establishment of a panel to determine if sterilisation is indeed needed and thus in the child's best interestis a very effect mechanism to ensure that no unethical or other negative conduct it permitted when deciding on the matter.

## 2.7 The National Health Act 61 of 2003

This Act places an obligation on healthcare providers and all staff to ensure that they are fully informed of the provisions of this Act and all obligations placed on them as medical practitioners. In terms of this Act the medical practitioner must explain all necessary information to the patient and acquire consent based on this information before any patient may be treated.[39] With regard to a child-patient relationship, the National Health Act reflects the same age threshold for children as was included in the Child Care Act:[40]14 years for medical treatment and 18 year for surgical procedures.

This Act also includes regulations that any disclosure of medical information pertaining to the treatment of a patient may only be made on acquisition of written permission by that patient. This would affect children in that children above 14 would be able to consent to the disclosure of his/her own medical information and those children under the age of 14 would need the assistance of their parents.

[36] S 2(1)(a)-(b) of the Sterilisation Act 44 of 1998.

[37] S 3(1)(b)(i)-(ii) of the Sterilisation Act 44of 1998.

[38]S 3(2).

[39]S 8.

[40] See par 2.2above.

TheAct also stresses that each patient has a right to actively participate in all matters concerning his or her personal health and events which may haveadverse consequences. This includes health status, proposed treatment or procedures, as well as all advantages and disadvantagesof these treatment options.[41]In section 8 the Act providesthat a person is entitled to partake in all decision making regarding his or her medical treatment if it appears that the person has the mental capacity to fully understand all the possible impacts of the proposed treatment, despite the fact that the person in question might be mentally incapacitated in terms of the common law. This places a direct obligation on medical practitioners to acquirethe necessary consent not only from the parents but also from the child-patient. This obligation exists regardless of whether that child is above or beneath the required age threshold. The available treatment options, all the risks and benefits of the treatment/procedure and the alternative options need to be discussed with the child-patient in full.

## 2.8 The Children's Act 38 of 2005

The Children's Bill was drafted by the Law Reform Commission over a lengthy period. The goal was to create an Act to incorporate a wide range of provisions pertaining to child law. In 2003 the Minister for Social Development submitted the Bill to Parliament, and the much anticipated Children's Act was approved in December 2005.[42]

Section 129 regulates the medical treatment of children since the Act came into play. This section dictates the pre-requisites of both medical treatment and surgical procedures. Although the Act supplies no clear distinction between medical and surgical treatment, it is safe to assume that surgical treatment includes all forms of invasive surgical procedures. Section 129 (2) – (3) read as follows:

> *"(2) A child may consent to his or her own medical treatment or to the medical treatment of his or her child if-*
>
> *(a) the child is over the age of 12 years; and*

[41]S 6.

[42]Section 129 came into force on 1 April 2010.

*(b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.*

*(3) A child may consent to the performance of a surgical operation on him or her or his or her child if-*

*(a) the child is over the age of 12 years; and*

*(b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and*

*(c) the child is duly assisted by his or her parent or guardian."*

The first noticeable change to the requirements for consent to medical treatment is the age threshold which has been lowered from fourteen to twelve.The second change is a requirement which was first brought to light in child law in the British *Gillick*-case[43] and is therefore commonly referred to in the legal world as the "Gillick competence test''. After it is established that the child is twelve years old, it has to be determined whether that child has *both* sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of the treatment. Only once this has been establishedis a child able to consent to his orher own medical treatment.

[43] *Gillick v West Norfolk and Wisbech Area Health Authority* 1985 3 All ER 402; See par 4.5.1 below.

# Chapter 3: Informed Consent

## 3.1 Introduction

Before the statutes are debated it is necessary to focus on theprerequisites for "informed consent". Consent is a lawful and ethical expression of a person's right to have his or her autonomy respected. Consent may be given either verbally or in writing. According to common law the following is regarded as lawful consent by a person.[44]

Firstly, consent must be given by a person who is enabled to give consent in accordance with the law.Secondly,consent may only be given after the person has received sufficient information about what he/she is consenting to. Finally,consent must be given clearly, unequivocally and comprehensively. These requirements will now be discussed.

### *3.1.1 Consent must be given by a person who is enabled to give consent in accordancewith the law*

In South Africa children are generally considered to have limited capacity as they are not always mature enough to respond to and understand the consequences of their actions.Using age limits to limit consent, the legislature aims to protect children from their own immaturity.These limits are mostly established by research regarding a child's level of maturity.[45]

### *3.1.2 Consent may only be given after the patient has received sufficient information regarding what he or she is consenting to*

A person may only consent to treatmentafter receiving adequate information regarding the full extent and nature of the relevant treatment. All possible information must be given in basic or layman's terms without any concealed intentions. In the circumstances where a child is the patient, the medical practitioner should place special emphasis on the use ofplain language that is easy for the child to understand.

[44] South African Law Commission Discussion Paper 105 (Project 122)*Assisted Decision-Making: Adults with Impaired Decision-Making Capacity* (2004)57 -58.

[45] Freeman (ed)*The International Library of Medicine, Ethics and Law: Children, Medicine and The Law* (2005) 489

### *3.1.3 Consent must be clearly, unequivocal and comprehensive*

For consent to be clear and unequivocal the patient and doctor must ensurethat mutual understanding exists. The doctor must beassured that the patient fully comprehends either treatment or procedure with all its probable advantages and risks. There must be no reservation between them.

## 3.2 South African Case Law

There are a few cases in South African law which deal with consent as was applied to the medical treatment of children. One of these cases is *Esterhuizen v Administrator, Transvaal*.[46]In this case a fourteen year old girl had to receive radiation treatment for odd little lumps underneath the surface of her skin. The first few treatments consisted of only light treatments on the surface of her skin which had no significant side-effects on the girl.However, a few years later the situationdeterioratedand the doctor responsible for her treatment decided to opt for more radical X-ray treatments in order to combat her illness.

During this time the girl lived with her grandfather while the girl's mother lived with her second husband in Swaziland. The grandfather was thus responsible for taking the girl to hospital to receive her treatments and the mother did not return to South Africa to attend the treatments. The mother testified the reason for this was "*ek het geweet sy was nooit siek as sy daardie goed aan haar was nie, en as sy die behandeling gekry het, was sy ook nie siek nie, en ek was nie bekommerd daaroor nie".*[47]When the doctor took the decision to change the treatment the possible side-effects were only known to him. The decision to change the treatment was never conveyed to the girl's mother. Before the treatment started the girl asked the doctor "What is going to happen now?" to which the doctor replied, "Don't worry".

Ten days after the new radical treatment was administered, blisters started appearing on the skin which caused a burning sensation. She was admitted to hospital where the treatment for the blisters was started immediately without any noticeable success. That same year both legs were amputated as a result of extensive tissue damage to her legs.

[46]1957 3 SA 710.

[47]*Idem* 715E.

Over the next five years the damage increased to such an extent that the doctor was left with no choice but to amputate both her hands above the wrists.

Inlight of the fact that the doctor was the only person who knew the full extent of the treatment and its possible side-effects, it was put to him in cross-examination why he did not see it as important to inform the mother or grandfather of the relevant facts. He replied:

> *"It was my function to cure the disease if it was possible...I was fully aware that there would be cosmetic changes under the circumstances after radiotherapy. I did not consider it necessary to discuss these details with the patient and I had never met the patient's parent ...it is not usual procedure in the radiotherapy department to ask the parents to come."*[48]

As a result of the gross negligence of the doctor in failing to acquire consent from a person fully informed of all the possible outcomes of the treatment Bekker J held that:

> *"[A] therapist, not called upon to act in an emergency involving a matter of death, who decides to administer a dosage of such an order and to employ a particular technique for that purpose, which he knows beforehand will cause disfigurement, cosmetic changes and result in severe irradiation of the tissues to an extent that the possibility of necrosis and risk of amputation of the limbs cannot be excluded, must explain the situation and resultant dangers to the patient – no matter how laudable his motives might be – and should he act without having done so and without secured the patient's consent, he does so at his own risk. The court makes it clear that it would not tolerate an omission by a doctor to inform the patient and guardian about all the possible outcome of a treatment"*[49]

## 3.3 Turning Point in South African Law

With regard to informed consent, the case of *Castell v De Greef*[50] should be noted. In this case principles of informed consent wereformulated. The case also hadasignificantimpact

[48] *Idem* 717A.

[49] *Idem* 717A.

[50] 1993 (3) SA 501 (C).

on future doctor-patient relationshipsand communicationsbetween doctors and patients in particular.

The respondent, a plastic and reconstructive surgeon, was sued by the plaintiff for a failed mastectomy. The patient had a history of breast cancer and had undergonepreviousssurgery.When more cancer tumours were discovered in her breast, her gynaecologistsuggested a mastectomy and referred her to the specialist. After the plaintiff and her husband consulted with the doctor, they decided to remove as much of the breast as possible in order to prevent the cancer cells from spreadingany further. During the same procedure the surgeon, assisted by a reconstructive surgeon, would re-build the plaintiff's breast.

After the procedure was completed, the plaintiff experienced noticeable discolouration of her skin caused by necrosis as well as the presence of an unpleasant odour. In addition, the plaintiff had an infection, unbearable pain and suffered trauma andhumiliation during this ordeal.

At no stage during the consultation did the doctor explain all the possible outcomes of this procedure to the plaintiff. The plaintiff claimed that not all relevant information regarding the procedure was given to her by the doctor andthus he did not obtain the required informed consent from her. If the plaintiff knew all the risks involved in this particular procedure, she would surely have opted for a procedure with a lesser degree of risk involved.

The court agreed with the plaintiff. The court heldthat not only was the plaintiff entitled to receive all the necessary information regarding the procedure, but the principles on informed consent was fixed in the South African law.

This case not only reaffirmed old legal principles but also, reinforced new attitudes. Firstly, the court placed patient autonomy above that of medical paternalism, thus shifting the professional medical standard of disclosures of information to favour the patient autonomy standard on disclosure. Secondly, the court found that a presumption must be created that

decisions regarding medical treatment of a patient must lie solely on the patient and not the doctor.[51]

## 3.4The Duty Placed on Doctors to Inform the Patient

South African law, like that of most other countries, places a legal duty on medical professionals to fully inform their patient of all the possible procedures available to choose from for treatment, as well as to disclose all information concerning each treatment. Only when a patient is equipped with all the information, is he/she in the best possible position to make an informed decisionregardingthe suitable treatment to opt for. The patient must be fully aware of all the relevant risks and benefits involved.

A doctor who fails to comply with this duty to inform may face detrimental liability as the patient is not in the position to give informed consent to the medical procedure. Van Oosten[52] discusses the relevant facets of expectations applicable to doctors in their duties of full disclosure. He draws a line between disclosure in regard to the nature of self-determination information and in regard to disclosure of risks and dangers.This is called the standard of self -determination, and is best articulated in *Canterbury v Spence:*

> *"The patient's right of self-decision shapes the boundaries of the duty to reveal. The right can be effectively exercised only if the patient possesses enough information to make an intelligent choice. The scope of the physician's communication to the patient, then, must be measured by the patient's need and that need is the information material to the decision. The law must itself set the standard for adequate disclosure. The scope of the standard is not subjective to either the physician or the patient."*[53]

In essence, the judicial stance has been to state that a doctor must provide information that a reasonable doctor would give a *reasonable* patient. The reasonable doctor standard can be expressed in several ways. The Victorian Law Reform Commission in its Discussion Paper on Informed Consent used the following definition:

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[51] Van Oosten"Castell v De Greef and the Doctrine of Informed Consent: Medical Paternalism ousted in favour of Patient Autonomy" 1995 *De Jure at p166*

[52]*Idem* 171.

[53]464 F 2d 772 (DC Cir 1972).

> *"A doctor must explain what he intends to do, and its implications, in a way a careful and responsible doctor in similar circumstances would have done. If the doctor is a specialist, the standard is 'that to be expected of an ordinarily careful and competent practitioner of the class to which the practitioner belongs....A doctor is negligent if the doctor does not provide information and advice to a patient that accords with the 'practice existing in the medical profession."*[54]

## 3.5 The Duty on Medical Practitioner to Inform the Patient

The duty to convey the information to the patient should be done by the medical practitioner in the best possible manner under the circumstances. The main purpose of the duty to inform is basically to protect the patient's freedom of choice and his or her right to self-determination. This is done by placing the patient (as a layperson) in the position to make a rational decision based on knowledge and appreciation of his or her medical situation.[55]In the absence of such information, real consent will be lacking.[56]

When informing a patient of the treatment, the doctor should use an approach which takes into account the specific circumstances of that particular patient. When this measurement is used in a case where a child is the patient, the doctor should take extra care with special consideration for the child-patient's ability to understand the communication.The development, education, background and experience of the child-patient must be considered. These assessments by the doctor are closely related to the nature of the duty to inform and the unique facts of each case should be considered to determine to what extent the patient must be informed.

It is very important thatthe medical practitioner remember that when he or she is informing a child-patient about a treatment or procedure, besides being a lay-person, that child is also inexperienced. A child can easily be intimidated by a person in a position of authority who might be using highly technical medical jargon in the discussion. An un-sympathetic approach by the medical staff might also frighten the child.

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[54]LRCV:1987:8.

[55] Van Oosten "Patient Rights: A status report on the Republic of South Africa" (1996) *Law in Motion International Encyclopaedia of Laws World Conference* 997.

[56]Van Oosten 1995 *De Jure* 197; *Castell v De Graaf* 1994 4 SA 408 (C).

## 3.6 The Practice of Therapeutic Privilege

In the case of *Lord Scarman in Sidaway v Bethlem Royal Hospital Governors*[57]the scope of therapeutic privilege is defined as follows:

> *"This exception enables a doctor to withhold from his patient information as to risk if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat ...of physiological detriment to the patient."*

Therapeutic privilege is when the medical practitioner intentionally withholds information regarding thepatient's medical conditionwhen the doctor believes that full disclosure may bepotentially harmful to the patient's physical or psychological well-being. This practice is commonly used in circumstances when it would not be feasible to disclose information to a patient. For example, in an emergency or other related circumstance when a doctor is of the opinion that the patient lacks the necessary capacity for decision making.

In the case of children, medical practitioners may be more inclined to use this method so as to avoid unnecessary distress or shock. But the Children's Act now states that a child who is above 12 and is of sufficient maturity may consent to his/her own medical treatment without his/her parents.[58] This could lead to possible mishaps by overworked and under staffed statehospitals andmedical practitioners. Without strict regulations in place in hospitalsand active monitoring of the level of service when treating unassisted minorsa significant risk for abuse and neglect is created. A child, who is inexperienced, illiterate and possibly intimidated by adults, may be misled regarding the proposed treatment under the veil of therapeutic privilege. Doctors, in particular are likely to be considered in a position of authority, by children.

[57] *Sidaway v. Bethlem Royal Hospital Governors* [1985] AC 871.

[58] S 129 of the Children's Act.

# Chapter 4: The Autonomy of a Child Patient

## 4.1 A Brief Background of Patient Autonomy

The Constitution of South Africa, specifically the Bill of Right in Chapter 2 guarantees all persons in South African autonomy over their bodies.[59]In one of the firstjudgments of the ConstitutionalCourt itwas pointed out that human dignity is one of the cornerstones of our new found constitutional "rule of law".[60]In its handling on human dignity, the Constitutional Court has reiterated the interdependency and mutual relationship between human dignity and other rights within the Bill of Rights, such as freedom, privacy,[61] right to life and equality.[62]The South African courts have justified autonomy as being anessential element of the right to human dignity. To give validity to these rights, the final decision to undergo or refuse a certain medical treatment, will always vest with the patient.This will apply in all situations where medical intervention is proposed, even when the refusal of a patient might lead to his or her situation worsening or could lead to the patient's death.The principle of patient autonomy states that in the absence of special circumstances medical treatment should not be undertaken against the will or without the consent of a patient. This principle is supportedin the South African law and the case law version of the common law doctrine of informed consent.[63]It is generally assumed that, in the absence of an emergency, violating a person's bodily integrity in the absence of consent would constitute an unlawful act of assault. Self-governance in respect of bodily integrity is a fundamental right upon with the expression on autonomy lies as perfectly stated by Isaiah Berlin[64] when he wrote:

> *"I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be an instrument of my own, not other men's, acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my*

[59]See s12(2):"*Everyone has the right to bodily and psychological integrity, which includes the right- (a) to make decisions concerning reproduction; (b) to security in and control over their body; and (c) not to be subjected to medical or scientific experiments without their informed consent*".

[60]*S v Makwanyane and Another*1995 (3) SA 391 329.

[61]*National Coalition for Gay and Lesbian Equality and Another v Minister of Justice and Others*1999 (1) SA 630.

[62]*Idem* 41.

[63] See 3.3 above.

[64]Berlin *Four Essays on Liberty (*1969) 131.

> *own, not by causes that affect me, as it were, from outside. I wish to be somebody, not nobody; a doer – deciding, not being decided for, self-directed and not acted upon by external nature or by other men as if I were a thing, or an animal, or a slave....**I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing responsibility for my choices and able to explain them by references to my own ideas and purposes."*** [Own emphasis added]

One case in which the Constitutional Court gives a clear indication of its position on autonomy is *NM v Smith.*[65]This case dealt with the unauthorized publication of the identities of three HIV-positive women in the biography of a highprofile politician. The three women were successful in claiming damages for infringement on their privacy, dignity and psychological integrity. Delivering the majority judgement O'Regan held:

> *"Underlying all these constitutional rights [human dignity, privacy and freedom] is the constitutional celebration of the possibility of morally autonomous human beings independently able to form opinions and act on them ... Our Constitution seeks to assert and promote the autonomy of individuals…"*[66]

## 4.2 The Competency of Children

To fully appreciate and utilise one's right to autonomy the person who wants to rely on this right must have the competency to understand the rights he/she is demanding. A child's competency to give informed consenthas been divided into three components: (1) the consent is informed (made knowingly); (2) the consent is competent (made intelligently); (3)the consent is voluntary.[67]

No clear test has yet been developed that consistently distinguishes competent people from those that are incompetent. South Africa is a nation with a multitude of races, cultures and religions which make its population unique and diverse. Given that competency is context-specific, it would be hard to imagine such a test being developed.Even if a non-culturally biased and objective test could be created, individual tests of every child requesting medical

[65] 2007 5 SA 250 (CC).

[66]Paras 145-146.

[67]Grisso & Vierling, "Minor's Consent to Treatment: a Developmental Perspective." 1978 *Professional Psychology* 9412-427.

treatment would turn out to be potentially high priced with regards to efficiency, respect for autonomy and privacy. Adults have traditionally been presumed competent, and children have been presumed to lack competency to some degree.

Section 129 of the Children's Act[68] uses both a threshold concept of competency or maturity as well as an age-standard. To some extent thisage-standard can be considered assubjective as one can easily find an individual above twelve years or even older who can be considered incompetent to consent to medical treatment. On the other hand one can also find a child under the age-standard that has the competency to give informed consent. Individuals above the age-standard are more likely to be competent than their counterparts under the age-standard.

## 4.3 The Importance of the Disclosure of Information.

The patient's right to information pertaining to the proposed medical treatment/procedure is a fundamental right in the South African medical law. Carstens[69] confirms the reasons for this as being:

> *"Ordinarily, lawful consent is out of the question unless the consenting party knows and appreciates what it is that he or she is consenting to. Since the patient us usually a layperson in medical matters, knowledge and appreciation on his or her part can only be effected by appropriate information. In this way, adequate information becomes a requisite of knowledge and appreciation and, therefore, also of lawful consent. In absence of information, real consent will be lacking. In turn, this means that the doctor, as an expert, is saddled with a legal duty to provide the patient with the necessary information to ensure knowledge and appreciation and, hence, real consent on the patient's part. The doctor's duty of disclosure is not treated as one of negligence, arising from a breach of care, but as one of consent in the contractual setting."*

What plays a significant role in the disclosure of information is not just the context of the information conveyed but also how this information is being communicated[70] or shared

[68] See par 2.8 above.

[69] Carstens 'Informed Consent in South African Medical Law with Reference to Legislative Development' available at http://new.samls.co.za/node/354 accessed on 1 October 2011.

with the patient. The process places a huge responsibility on the medical practitioner to devise a means to convey potentially disturbing news to the patient and limit the amount of emotional and mental distress for the patientat the same time. The purpose of this is to ensure that the patient plays a continuous role throughout the decision-making process. This limits the possibility for possible excuses for making decisions on behalf of the patient.

To avoid emotional and mental distress of the patient, especially in a child who has very limited life experience, the medical practitioners should develop a special approach in the disclosure of this information.The medical practitioner should be empathetic and sensitive when explaining the treatment or procedure with the child-patient, keeping in mind the child's age, gender, background and the emotional weight this news will place on the child. This might prove more complicated than merely checking off list of guidelines, as will be discussed later. While it is clear that certain difficulties may arise in informing the patient the ever-present risk of therapeutic privilege, Burchell believes that the key to this problem lies not in the rejection of the concept of informed consent, but rather in improving the necessary communication skills in order to equip medical practitioners to deal with the situation as proficiently as possible.[71]In doing so Ley[72] believes that the following benefits of improved communications are achievable:greater patient satisfaction; better co-operation with treatment regimens; an easing of patient's possible anxiety or distress. This would result in faster recovery and a shortenedhospital stay.

Child-patients can be a lot harder to deal with than their adult counterparts. They are the leastable type of layman and the most in need of information due to their lack of knowledge

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[70]Steps may include: (1) explicitly identifies different analytic steps in the treatment decision-making process; (2) provides a dynamic view of treatment decision-making by recognizing that the approach adopted at the outset of a medical encounter may change as the interaction evolves; (3) identifies decision-making approaches which lie between the three predominant models (paternalistic, shared and informed) and (4) has practical applications for clinical practice, research and medical education. Rather than advocating a particular approach, an emphasis on flexibility is important with regards to the way that physicians structure the decision-making process so that individual differences in patient preferences can be respected. (Acquired from "Decision-making in the physician–patient encounter: revisiting the shared treatment decision-making model" 1999 *Social Science & Medicine* 651-661).

[71]Burchell "Informed consent – variations on a familiar theme" 1986 *Medicine and Law* 293 300.

[72] Ley *Communicating with patient: Improving communications, satisfaction and compliance* (1988).

and experience in medical matters. Careful and sensitive communication must be provided so that children can give informed consent.

## 4.5Autonomy Versus "Best Interest"

### *4.5.1 The Gillick case*

As was seen in the discussion ofthe South African courts' interpretation of patient autonomy, emphasis is placed on the independent ability to form an opinion and to act in accordance with the knowledge. This same argument was made when the Children's Act was drafted. The question is: where does one draw the line between the children's right to his or her own autonomy apart from his/her parent, and the duty placed on a parent to protect, educate and prepare the child for the responsibility of adult life? One of the most instructive cases regarding child autonomy is the Gillick case.

The English case of *Gillick v West Norfolk and Wisbech Area Health Authority*[73] is regarded internationally as a benchmark judgment for child law development.This judgment by the House of Lords found that parental authority is secondary to that of the child, when that child possesses sufficient maturity and intelligence to make an informed decision on her/his own. This judgment was a result of a legal dispute between Victoria Gillick and the Department of Health. The Department of Health had issued a memorandum which gave doctorsthe necessary authority to advise sixteen year old girls on pregnancy prevention and supply them with contraceptives without their parents' consent or knowledge.

The House of Lords found this memorandum to be legal. In his majority judgment Lord Scarmen held:

> *"A minor's capacity to make his or her own decision depends on the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit".*

This judgment played a considerable role in the drafting of thenew Children's Act[74] of the British legislature. It then swiftly spread to the commonwealth law systems and was adapted in most of Britain's former colonies.

[73]1985 3 All ER 402.

[74]Children Act 1989.

The concept of competence is central to the laws handling matters of consent. The Gillick-case describes competence as the child's ability to understand information about the proposed medical treatment or procedure. As discussed, this may include the treatment's goal, risks, likely effects, prognosis and the availably of other and possible less invasive alternatives.

The patient may sometimes interpret the available information differently from the medical practitioner. Sometimes unwise choices are made. Thisis permitted due to the patient's right to autonomy. Another view is that understanding may not always imply that the patient is making his/her decision on rational basis. Many decisions made by a person in everyday life are not necessarily made rationally but are rather based on an emotion.

In everyday life, the levels of understanding regarding the proposed treatment will mostly be affected by the risk vs. benefit factor. If the medical practitioner proposes a simple and effective treatment the patient who refuses to undergo the treatment is more likely to be considered incompetent. On the other hand, when the treatment proposed is dangerous and the risk and/or benefits are unpredictable, a lower benchmark will likely be selected in order to protect the patients' right to autonomy and bodily integrity.

Some practitioners in the medical fraternity feel that children who refuse treatments or procedures for whatever reason generally demonstrate a much greater level of understand than their peers who consent. In this regard, Pearce argues that:

> *"The consequences of withholding consent to treatment are usually much more significant and potentially dangerous than simply giving consent… A more stringent test should therefore be applied when assessing a child's ability to refuse consent than when assessing competence to consent."*[75]

He goes on to explain the difficulty in finding a balanced approach:

> *"There is a danger of using 'in the best interests of the child' as an excuse for poor communication and for failing to take the necessary time to explain the proposed treatment properly. At the same time there is also a risk of placing an unacceptably*

75Pearce"Consent to treatment during childhood. The assessment of competence and avoidance of conflict" *1994British Journal of Psychiatry 713.*

> *high level of responsibility on the child which can release parents from their own duty of care."*[76]

It will be difficult to create a level of understanding that can be considered adequate in dealing with a child-patient. Choices made regarding consent will in most case weigh on the method of communicationand the necessary information for the child to understand. As put by Roth, a clear definition with regards to competency in this matter is hard to find:

> *"The search for a single test of competency is a search for a Holy Grail… In practice, judgments of competency go beyond semantics or straightforward applications of legal rules; such judgments reflect social considerations and societal biases as much as they reflect matters of law and medicine."*[77]

### *4.5.2 The Family as the Locus of Decision Making*

When it is concluded that the child-patient does have decision-making capacity, section 129 of the Children's Actconcludes that the child should give informed consent for themselves. This poses a possible problem in practice. The Children's Actassumes that decision-making capacity can be defined and measured. However, the Act offers no definition of competency. It also does not contain regulations or guidelines for the test of decision-making competency or maturity.It canbe arguedthat an individual assessment for maturity should be made in each case. This might prove to be difficult in the absence of clear criteria on which to base maturity or decision-making competency. The decision will then solely rest upon the assessment made by the attending medical practitioner,who may not have the training to make such an assessment.

By deciding that a child is mature enough to give informed consent in the absence of his/her parentsand respecting the child's decision, the medical practitioner is replacing the parents'judgment. This is less an issue of respecting the child's autonomy, and more a case of deciding who knows what is best for the child. It might be assumed that parents in general are the best judges, as they are more attentive of their child's well-being and are responsible for the child's everyday needs.This is not a justification for ignoring the

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[76] *Idem 715.*

77Roth Meisel & Lidz 'Tests of "competence to consent to treatment"' *1977American Journal of Psychiatry 283.*

children's views and needs when making health care decisions, especially with regard to mature children. Medical treatment and procedures should be carefully explained to the child. This will enable him/her to fully understandwhat will be done to them. This will also allowthe child to voice his/her views on the matter.In allowing the parent to participate in some way when decisionsare made about their child's health care, the parent can actively support and help the child learn to make these kinds of decisions responsibly.

### *4.5.3Child Autonomy*

When child autonomy is discussed, one generally finds two main streams in the children's rights movement: those who are in favour of child protection and those who are in favour of child autonomy.

The protection movement sees children as vulnerable and dependent on the protection of their parents to help them again the dangers and sometimes from their own inexperience. The child autonomist on the other hand argues that children are rights bearers and that children's rights should not been seen a mere extension of the rights of their parents. In reality both these view should be balanced against each other to find the perfect environment for a child to develop in.[78]

When a child as young as twelve years old consents to his/her own medical treatment, one should ask if allowing that would promote not only the child short-term autonomy, but also his/her life-time autonomy. If one looks at the value placed on the right to self-determination, it is justified for an adult to have the right to autonomy in that they enjoy some level of life-experience. In respecting a young child's rights to autonomy, one may promote his/her present day autonomy, but what about the child's life-time autonomy? Children need a period of time in which they are protected, in order to develop habits of self-control andinformed decision making to advance their opportunity experience and life-time autonomy.

The reason for limiting younger children's present-day autonomy is the fact that these children make every day decisions based on limited life experience and this could possibly lead to a child making decisions that does not form part of a well-conceived plan. Children, especially younger children, have a greater potential for developingtheir skills of critical

[78]Boezaart (ed). 2009 Child Law in South Africa. Juta at p 247

refection and self-control. By shielding the child from his/her own possible lack of life experience, the parent/care-giver can help the child obtain and develop the capacities that will enable him/her to make better decisions to promote his/her own long term well-being.

In section 28(1)(b) of the Constitutionstates that: "*Every child has the rightto family care or parental care, or to appropriate alternative care when removed from the family environment.*" This section reiterates the important role that parents or the family environment plays in the child's development. It aids the interest of the child to have an autonomous parent who can assist him/her to become capable of conceiving and implementing his/her own plans for life." In offering assistance to the child in areas of everyday life where the child lack experience, the parent can assist the child in promoting his/her own autonomy and utilize it to his/her best life-time autonomous potential.

# Chapter 5: The Concept of Maturity

## 5.1 Introduction

What is maturity? When is one mature? Can it be clearly defined and measured? Firstly, we must define maturity and distinguish between the different types of maturity. Maturity is defined as a "full development, full grown."[79]According to Merriam-Webster, mature is defined as having completed natural growth and development. That is, being fully grown, complete, ready.[80]

There are mainly two types of maturity in human development namely, physical maturity and emotional maturity. The first type of maturity, the physical maturity, is scientific, visible and quantifiable and can be measured by the key milestones in the biological development of a human being. For the purpose of this study, the physical maturity of a child will not be dealt with.

## 5.2 Emotional Maturity

Emotional maturity, which has direct impact on the child's ability to make decisions, is examined here in an attempt to indicate the role thereof within the child's decision making process. The consequences thereof within the ambit of the new Children's Act are discussed.

Emotional maturity is one's "full development" emotionally.[81]Emotionally maturity does not refer to physical enhancement, but rather psychological development.[82]

The characteristics of emotional maturity according to the Maryland Institute are as follows:[83]

[79]MacMillan Dictionary definition of 'maturity' available at http://www.macmillandictionary.com/dictionary/british/ maturity accessed on 9 December 2011.

[80] 'The 7 Criteria of Emotional Maturity.' available at http://blognewscast.com/article/294994-the_7_criteria_of emotional_maturity.htm accessed on 3 November 2011.

[81]MacMillan Dictionary definition of 'full development'.*www.macmillandictionary.com*

[82]'Emotional Maturity' available at http://humanresourcessouthafrica.co.za/emotional-maturityaccessed on 3 November 2011.

*"1. The ability to experience and understand our own deepest feelings and needs, and to be able to act on and express these feelings and needs in appropriate andconstructive ways. This is opposite from "acting-out" our needs in unconscious, destructive patterns of behaviour. This aspect of maturity includes the ability to experience and tolerate especially intense feelings - which inevitably occur in life - and to be able to appropriately express these feelings, or contain them until an appropriate and responsible means for expressing them is available.*

*2. The ability to act on and react to life circumstances with intelligence, sound judgment and wisdom. This aspect of maturity is opposite the tendency toact impulsively, without taking the opportunity to think through our actions or consider their consequences. (Wisdom: having the quality of good judgment, learning and erudition, soundness.)*

*3. The ability to recognize, empathize with, and respect the feelings and needs of others. This is opposite from a selfish and chronic preoccupation with ourown needs, with no awareness of, or sensitivity to, the needs of others.*

*4. The ability to delay the immediate satisfaction of our own needs, so that we may attend to other more pressing needs or actions. This is opposite from condition in which our immediate needs always take precedence over all other needs.*

*5. The ability to love - to allow another's needs, feelings, security, and survival to be absolutely paramount - just as if these were our own.*

*6. The ability to adapt flexibly and creatively to life's changing circumstances and conditions. This is distinct from the tendency to respond to life's challenges in rigid, outmoded behaviour patterns that are no longer particularlyeffective or appropriate.*

*7. The ability to channel our energy, both positive and negative, into constructive contributions to ourselves, to others, and to our communities.*

*8. The willingness and ability to be responsible and accountable for our own circumstances and actions in life, and the ability to differentiate our responsibilities from those of others. This is distinct from blaming others and seeing ourselves primarily as the victim of other's behaviour, or from maintaining a sense that we are*

[83] Maryland Institute 'A multi-Speciality Mental Health Practice' available at http://mysite.verizon.net/vzep0oet/maturity_criteria.htmaccessed on 7 November 2011.

*somehow responsible for the happiness andwell-being of all those around us. Responsibility arises from a stance of strength and competence; it does not include pronouncements of blame, shame, guilt, or moral inferiority/superiority, as all these are judgments added to thebasic condition of responsibility.*

*9. The ability to relate comfortably and freely with others, to like and be liked by others, and to maintain healthy and mutually satisfying relationships.The ability to choose and develop relationships that are healthy and nurturing, and to end or limit relationships that are destructive or unhealthy..."*

Menninger, (MD, psychiatrist and co-founder of the world-renown mental health center the Menninger Clinic in Houston, Texas) agrees with most of the above characteristics of emotional maturity and suggests that the following areindicatorsof an emotionally mature person:[84]

*"(1) The ability to face reality and deal with it constructively;*

*(2) The capacity to adapt to change;*

*(3) A relative freedom from symptoms that are produced by tensions and anxieties.*

*(4) The capacity to find more satisfaction in giving than receiving.*

*(5) The capacity to relate to other people in a consistent manner with mutual satisfaction and helpfulness.*

*(6) The capacity to direct instinctive hostile energy into creative and constructive outlets.*

*(7) The capacity to love."*

Kuehn[85] goes on and explains these factors in detail:

*"1. The ability to deal constructively with reality*

*To deal with reality in a constructive manner, we must face truth, the facts, rather than deny them… There are healthy and constructive ways to cope that lead to greater emotional maturity and growth. It may not be the easiest path to take, but it leads to healing, lasting comfort and hope.*

[84] http://www.menningerclinic.com/resources/emotional_maturity.htm.

[85] 'The 7 Criteria of Emotional Maturity.' available at http://blognewscast.com/article/294994-the_7_criteria_of emotional_maturity.htm accessed on 3 November 2011.

*2. The capacity to adapt to change*

*Change is not always easy. It can turn our world upside down at times and cause a great deal of stress. …adapting to change is to make necessary adjustments. Sometimes the most important adjustment is in our attitude. Change can annoy us as it disrupts our routine and expectations, but we can choose to accept it and allow ourselves time to get comfortable with change.*

*3. A relative freedom from symptoms that are produced by tensions and anxieties*

*The symptoms produced from tensions and anxieties can include physical distress (headaches, stomach problems, rapid heart rate) and emotional distress (worry, restlessness, panic). Anxiety is a major mental health problem affecting millions of people every day. It negatively affects all levels of people's lives--their mental and physical health, relationships, and work. To live free of its destructive symptoms and consequences is to cope with life stress in a healthy manner, learn to relax, release worries, and develop inner peace.*

*4. The capacity to find more satisfaction in giving than receiving*

*People who give of themselves--their time, attention, help, finances, or what they are able-- are generally more fulfilled and happy than those who do not. People who are primarily takers are more likely to use others for their own personal gain and are often considered selfish, stingy, and/or greedy.*

*5. The capacity to relate to other people in a consistent manner with mutual satisfaction and helpfulness…. life is all about relationships. We relate to others every single day--whether it is a relative, co-worker, neighbour, or stranger, our lives are intertwined with others. Love and respect are two key factors to relating successfully to others…*

*6. The capacity to sublimate, to direct one's instinctive hostile energy into creative and constructive outlets*

*If we were to release all our frustrations and anger on the world, we would have a hostile existence. Instead, we can take that energy and direct it into something good and productive. It has long been said that sports is a great outlet of extra energy. Anything that is positive, constructive and creative can redirect our energies and put them to good use…*

*7. The capacity to love*

*Love is the greatest power in the world. As humans, we are born with the capacity to love. The greatest differences between us are how we communicate our love. Love cures people - both the ones who give it and the ones who receive it."*

In the last decade or so, science has discovered a tremendous amount about the role of emotions in our lives. Researchers have found that even more than IQ, your emotional awareness and abilities to handle feelings will determine your success and happiness in all walks of life, including family relationships.[86]

From the above reasoning we can determine that emotional maturity depends first upon experience, but experience does not necessarily lead to development. Our experiences can result in detrimental changes that hinder our maturity. Put differently, our experiences can prohibit our emotional development. Maturity has more to do with the types of experiences you have had and what you have learned from them and less to do with how many birthdays you have celebrated.

This means that, as human beings, we must use all measures to translate these experiences into positive development. This medium is reason. Our rational facilities also allow us to process this information. The progress of our emotional development depends on how we manage this information.

Maturity and age are not necessarily related. Maturity is the capacity to respond, manage and analyse in a manner suitable to a particular situation. Maturity is thus learned through experience and comes from vigorous development or progress. Direction in managing emotional situations is required to nurture positive maturity. The way in which a person deals with an emergency or formulates decisions are good signs of their level of maturity.

In addressing the maturity of children hereafter, it will be apparent that a clear definition of maturity depends on the situation. A child might be considered mature enough for a certain task, but given another situation he/she might be considered to be immature. In the

[86] 'The 7 Criteria of Emotional Maturity.' available at http://blognewscast.com/article/294994-the_7_criteria_of emotional_maturity.htm accessed on 3 November 2011.

Babysitter Test[87] it is revealed that there are "*deep incongruences in the way the maturity of the same children are appreciated for two different tasks*".

## 5.3 Maturity of the Child Patient

The reality underlying all research into the maturity of children is that each child is an individual, growing up in a unique constellation of relationships and resources, opportunities, strengths and weakness.[88] In fact, one size will never fit all.[89] One should always be careful to view each child as a unique human being who deserves our greatest wisdom and our full compassion.[90]

To better understand what a test for maturity would entail should section 129[91] contain such a test, I interviewed Dr. Irene Strydom.[92] According to Dr.Strydom language plays a very important role in determining maturity. Verbal capabilities such as vocabulary, long and short term memory, conclusive reasoning, arithmetic capabilities as well as non-verbal capabilities such as inductive reasoning, two and three dimensional concepts are concepts subjected to the language capabilities of the child. Dr.Strydom noted that a child patient's ability to make a decision is based on a number of factors.

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[87]Koren"Maturity of children to consent to medical research: the babysitter test" 1993*Journal of Medical Ethics*142-147.

[88]Garber *Developmental psychology for family law professionals; theory, applications and the best interest of the child* (2010) 3.

[89]*Ibid.*

[90]*Idem* 20.

[91]38 of 2005.

[92]Dr Irene Strydom(B Prim, Dipl Rem Ed, BEdHons - Gifted ChildHonsBEd- Guid&Couns [Endorsement] MEd, MEd - Guid&Couns MA Couns Psych DEd Counselling Psychologist Educational Psychologist).Dr Irene Strydom completed two Master's degrees in Educational Psychology (1991) and Guidance and Counselling (1999) at UNISA, both with distinction and received performance awards from UNISA for both these degrees. In 1995 she received her Doctorate from UNISA. Irene also completed three certificate courses at the University of Johannesburg in 2003 (Certificates in Psychopathology, Neurology and Personology) and a Master's degree (with distinction) in Counselling Psychology (University of Pretoria) in April 2008. Irene Strydom is registered as an Educational and Counselling Psychologist and runs a private practice. She used to head the Brooklyn Child and Adult Guidance and Development Centre in Pretoria, where therapeutic and remedial services are offered. Irene was a senior lecturer at the University of South Africa (UNISA) till 2007 where she trained registered counsellors and educational and counselling psychologists.

Firstly, the child's intellectual development and his/her ability to utilize concepts grasped since childhood which have developed through the years to assess a situation and to take decisions based on those concepts, and adjustingto current circumstances is important for a mature decision.

The second factor is the child's intelligence. There might be a discrepancy of the IQ of a child and his/her school performance. A child may have a very high IQ but a low performance at school. Mother tongue or home language education, testing and evaluation are prerequisites to determining the performance capabilities of a child. If any of these factors are not available in the child's mother tongue language the child will be at a disadvantage in the test for maturity.

Dr.Strydom pointed out that language poses the greatest problem in assessing the maturity of children. A test for maturity must be done in the child'shome language. If a child is educated in a second language or tested in a second language, the child would perform negatively in the testing of the ability to grasp concepts.

The third factor which comes into play is the child's emotional stability. Normal family structures, where loving and caring parents play a pivotal role in a child's upbringing result in a positive outcome. Signs of abuse, neglect, substance abuse and other negative family factors have an adverse impact on emotional stability.

The fourth factor in accessing the child's maturity of decision making is the schooling of his parents. The child may be more mature that his/her parents due to the lack of basic education of his/her parent. The South African rural child may be better educated that his/her parents and the medical decision which he might need to take regarding the treatment may be in conflict with the financial abilities of his/her parents. The child may understand that he/she requires medical treatment for i.e. his eyes or ears but his parent does not have the ability to pay for such a procedure or even understand the importance of such medical intervention in relation to the development of the child. This would lead to the strong possibility of conflict between the child and the parent/adult.

Another factor which Dr Strydom feels has an impact on a child's ability to make decisions is the system in which the child is raised. If the child is raised in an undesirable environment the child will need support in medical decision making. The HIV pandemic has caused the

death of several thousands of parents and created child-headed households. These children are, according to Dr Strydom, prone exploitation by medical practitioners who may wish to gain experience in procedures which might not be critically necessary. These proceduresmight be performed not for the sole benefit of the child but for the purpose of gaining experience. Dr Strydom noted that 'the White Jacket' of a doctor can possibly be perceived by patients as a symbol of authority and knowledge. This may lead to the perception that the doctor is trustworthy and the child patient will treat the doctor as such.

The cultural background and upbringing of the child may posea further threat to the child patient. A child may be accompanied by an adult who, due to their educational background and cultural constraints, are in no position to act on behalf of the child patient or to take decisions or access the medical information to assist the child in his/her decision to proceed with or refuse the proposed medical treatment.The Children's Act should give clear guidelines in the possible form of regulations to protect children from these circumstances.

It should be remembered that cultural and social norms and expectations impact on cognitive development. Some theorists have focused on the impact of culture, gender and social forces on cognitive development and have argued that culture may not only influence the rate of cognitive development, but also the mode of thinking that develops.[93]

[93]Swartz de la Rey & Duncan *Psychology, an Introduction* (2004) 76.

# Chapter 6: Possible Problems Regarding the Medical treatment of Children under the Children's Act

## 6.1 Introduction

Arguments for and against child participation in the decision-making process has for years been debated. The Children's Act envisages the most comprehensive inclusion of child participation to datein the medical treatment of children in South Africa.

There are however moral and practical reasons why thoughtfulness is required in the use of this Act. One such instance would be in the presentation of child and parent conflict with regards to what avenue is best in medical decision making. Parents need a moral and legal sphere in which to exercises these obligations[94] towards their children, in promoting not just their present-day autonomy, but also their lifetime autonomy.[95]

The mainweakness in section 129 of the Children's Act, is that the section has no clear definition of what maturity and decision-making capacity is, nor does it contain any test or guidelines in ascertaining this knowledge. In the absence of a clear test or guidelinesfor testing the maturity or decision-making capacity of children, it would be left in the handsof the attending medical practitioner. In some instance the practitioner would not be equipped with the necessary training to do this. The test to determine if a child is matureis a subjective test.

The duty to convey information to the patient should be discharged by the medical practitioner in the best possible manner under the circumstances. The main purpose of the duty to inform is basically to protect the patient's freedom of choice and his or her right to self-determination by placing the patient in a position to make a rational decision based on knowledge and appreciation of his or her medical situation.[96]

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[94] S 28 (1) (b) of the Constitution:*Every child has the right- (b) to family care or parental care, or to appropriate alternative care when removed from the family environment.*

[95] 4.5.2 supra.

[96] Van Oosten "Patient Rights: A status report on the Republic of South Africa. Law in Motion" 1996*International Encyclopaedia of Laws - World Law Conference* 997.

With no guidelines or test for maturity, the medical practitioner is ill-equippedtofulfil these requirements. He/she has to make sure that in assessing the child maturity and conveying this information, he/she attempts to do so in the mother tongue of the child as explained by Dr Strydom above.[97]

But conveying this information to the child in an understandable manner may prove challenging. South African law places a legal duty on medical professionals to fully inform their patients of all the possible procedures available for the patient's treatment. Medical professionals also have a duty to disclose all information concerning each treatment. Only if a patient is equipped with all the informationand is fully aware of all the relevant risks and benefits involved is he/she in the position to make an informed decision regarding his/her medical treatment.

When conveying this information, one should caution on the manner in which it is conveyed. Although the ethics of the medical practitioner is not necessarily in question, the manner in which the information is conveyed to the child patient has a direct bearing on his/her consent to the medical treatment. Means of improving the practice of working with children and young people and helping ensure better outcomes for the most vulnerable, need to be found.When conveying any message with a preconceived purpose, it is important to attend to the structure within which the attention of the recipient (child) can be drawn.[98]The communicator (in this study, the communicator is the medical practitioner) must possess of background knowledge of the recipient (child patient). For any communication to be effective, the importance of knowledge of the particular circumstances and background of the recipient (the child patient in this case) cannot be underestimated.[99]

The medical practitioner might have to change the attitude of the patient who haspreconceived ideas regarding a procedure that is vitally required. At this stage, the

[97]See par 5.2 above. According to Dr. Strydom, language plays a very important role in determining maturity. Verbal capabilities such as vocabulary, long and short term memory, conclusive reasoning, arithmetic capabilities as well as non-verbal capabilities such as inductive reasoning, two and three dimensional concepts are concepts subjected to the language capabilities of the child.

[98] Du Preez 86.

[99] Du Preez 87.

medical practitioner will find himself in the field of rhetoric. The Greek philosopher Aristotle described rhetoric as "the power to see the possible ways of persuading people about any given subject".[100]

The form, content and presentation of a specific message an important role in attaining the specific goal, whether it be to change the attitude or behaviour.[101]The ability of the recipient (in this study the child patient) to interpret, understand and assimilate the message and his ability to recognise that he/she needs to question the procedure/treatment andmight need to ask for supplementary or further information, to take a well-versed decision, will depend on the recipients (the child who required medical treatment) frame of reference, background knowledge of the subject, intellect and language ability.[102]

The essence of the message which is communicated by the medical practitioner, can be received negatively by the recipient (child patient) if the emotional conceptualisation of the thought or notion changes the intent of the original message. The risk of this suggestion can be described as follows:"*If the effective meaning of the message predominates over the conceptual meaning, the listener/ reader will fail to make a proper appraisal of what is being said.*"[103]

If the child is emotionally immature and thus not able to understand the true meaning of the concept which the medical practitioner is trying to explain, an emotional and ill-informed decision will be taken. The problems surrounding the test for maturity as discussed earlier and can not be ignored.

If the medical practitioner is aware of the emotional immaturity of the child, he/she couldgive the wrong impression and by so doing influence the child's decision on the required medical treatment or procedure. The Children's Act does not differentiate

[100] Du Preez 87.

[101] Du Preez 87.

[102] Dr Strydom states: *"Child patients should be fully informed on the medical procedures and treatments they are about to receive. In the case of a child patient the choice, alternative to the treatments and the various options available should be clearly communicated to the child. The art of persuasion for a specific choice should not be underestimated"*

[103] Du Preez 19.

between emotional and intellectual maturity. The need for a clearly defined protocol for communication with child patients in relation to consent to medical treatment is thus acknowledged.[104]

[104] Dr Strydom states: "*In circumstances where invasive medical treatment or surgery is suggested, a should access the situation in total. Ideally a social worker, psychologist, legal entity and of course a senior medial practitioner should be on the panel to access the treatment suggested by the practising doctor.*"

# Chapter 7: Conclusion

During this study, the consent required by a child for his/her medical treatment was discussed with all the aspects that play a pivotal role during this process. It can be said that the Children's Act has brought about a welcomed move in empowering children to enforce their right to autonomy. But, as was also pointed out, those rights may sometimes need to be limited for the purpose of protecting the child from his/her own inexperience. Children need a period of time in which they are protected in order to develop habits of self-control and informed decisions making. This is necessary for the advancement of their opportunity experience and lifetime autonomy.

For the purpose of protecting the child, section 129 placed not only an age threshold of 12 years, but also a test to ensure the necessary maturity is present to give informed consent. The absence of guidelines in testing for this maturity could leave medical practitioners in the dark as they are not trained to handle these child patients.

In order to avoid the unwanted emotional and mental distress, especially in a child who has very limited life experience, the medical practitioners should develop special approaches in the disclosure of this information. The medical practitioner should be empathetic and sensitive when explaining the treatment or procedure to the child-patient. The practitioner should keep in mind the child's age, gender, background and the emotional strain this news will place on the child. This could prove more complicated than checking a list of guidelines.

This clearly merits the need for regulations and guidelines to support section 129 in achieving the goals it set out to achieve. Firstly, medical practitionersin both private and public spheres should be given the necessary training and literaturewhich will enable them to familiarise themselves with the information needed when treating children. This is especially relevant where children are not accompanied by their parents.As part of this training, emphasis should be placed on the communication between doctor and child and the language used. Although it is not always possible, attempts should be made to communicate to the child in their mother tongue.

In addition, the doctor should attempt to ascertain the child's background and education. With the proper training this will enable the medical practitioner to determine the

correctmethod to convey the information to the child at a level which the child can understand.

When proposing a treatment or procedure, a medical practitioner may need the assistance of a third partyin order to convey the information.[105] This is not always realistically possible as understaffing and budgetary constraints are common in most of South Africa's health care system. It is proposed that when dealing with general ailmentsthe doctor is more than equipment to conduct the treatment of the child on his/her own. It would however be more difficult when treating a child for a serious illness or injury where radical or invasive action is needed. In these cases the medical practitionermay require the assistance of a social worker, psychologist or psychiatrist.This is not required in emergency situations, but would not only improve the treatment process for the child, but to also allow the medical practitioner to provide the best possible carewhilst still respecting the child's right to autonomy.

Children form a critical part of a countries population as they are the future of that nation. The role of children has made remarkable head way in the last few decades. This role has developed from the notion of 'a child should be seen and not heard' to being a part of society with comprehensive rights and increased autonomy from their parents. Yet, children are also the most vulnerable part of the population. As such, they are awarded protection in various forms including protection from their own immaturity. The purpose is to enable a child to develop into the best adult he/she can be, and to promote life-time autonomy.A means of improving practice in working with all children and young people needs to be found in order toensurea better outcome for the most vulnerable.

***Word Count 13310***

[105] In the form of a social worker, psychologist or psychiatrist.

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