

**AN EXAMINATION OF THE RIGHTS OF
THE CHILD TO REFUSE MEDICAL
TREATMENT: A SOUTH AFRICAN
PERSPECTIVE**

BY

PRIANKA ROXANN CHETTY

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**SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
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DECLARATION

I, Prianka Roxann Chetty, student number 211501722, hereby declare that the dissertation entitled

An Examination of the Rights of the Child to Refuse Medical Treatment: A South African Perspective

is the result of my own research, unless specifically indicated to the contrary, and that it has not been submitted in part or in full for any other degree or to any other university.

Signature:

Date:

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CHAPTER ONE

Introduction

'There can be no keener revelation of a society's soul than the way in which it treats its children.'

1.1. Background

The above statement by former President Nelson Mandela provides the basis upon which we must ensure and protect the rights of the children of South Africa.¹ In order to sustain our democracy, it is imperative that we prioritise the health and general well-being of our children.² To this end, the rights of children must be realized and in particular, the right to refuse medical treatment. Since the introduction of the Constitution of the Republic of South Africa³ (hereafter referred to as 'the Constitution') children have been regarded as a 'vulnerable group' requiring protection⁴ as they were seen as individuals who were incapable of making decisions independently; however, the extent of such protection has been debatable.

Prior to the enactment of the Children's Act 38 of 2005 (hereinafter referred to as the 'Children's Act') the right to consent to medical treatment was governed by the Child Care Act 74 of 1983 (hereafter referred to as the 'Child Care Act'). According to the Child Care Act, children were legally permitted to consent to their own medical treatment once they had attained the age of 14 years, and no further consent from their parent or guardian was required.⁵ Doctors were in the practice of treating children under the age of 14 years without parental consent as long as they proved to be of sufficient maturity to understand the treatment that was being performed on

¹ K Abrahams & T Matthews 'Child Rights Manual: Handbook for Parliamentarians.' (2011) Cape Town: Parliament of the Republic of South Africa *UNICEF* 3.

² *Ibid.*

³ 1996.

⁴ E du Plessis, A Govindjee, G van der Walt, 'The Constitutional rights of children to bodily integrity and autonomy.' (2014) 35 1.

⁵ Section 39 (4) of the Child Care Act 74 of 1983.

them.⁶ Doctors treated children under the age of 14 years as long as they appeared to be sufficiently intelligent and ‘grown up’ to agree to and undergo the treatment independently.⁷

1.2. The right of the child to consent to medical treatment as provided in terms of the Children’s Act 38 of 2005

The Child Care Act was soon replaced by the Children’s Act. This altered the age at which children were able to consent to their own medical treatment. Children are currently considered to lack the capacity to consent to their own medical treatment if they are below the age of 12 years, or if they lack maturity and understanding about the required medical treatment.⁸ It is for this reason that children are believed to be in need of protection from making significant decisions regarding their health. This need for protection has initiated the enactment of legislation such as section 129 (2) of the Children’s Act which clearly imposes the age restriction of 12 years on children consenting to their own medical treatment. In addition to this age restriction, children must be of sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment.⁹ Pursuant to this section, the law is clear about the child’s right to consent to medical treatment, however, what remains undetermined is the child’s right to refuse medical treatment.

1.3. The child’s right to refuse medical treatment

As mentioned above, the law is objectively clear about the right of a child to consent to medical treatment. The refusal of medical treatment, however, is not governed by South African legislation. The existence of the right of children to refuse medical treatment has been inferred by section 129 (2) of the Children’s Act. This section sanctions the right of a child to consent to

⁶ M Brazier & E Cave *Medicine, Patients and the Law* (2007) 4 399.

⁷ *Ibid.*

⁸ Section 129 (2) (a) – (b) of the Children’s Act 38 of 2005.

⁹ Children’s Act 38 of 2005 *supra*.

medical treatment and considering that refusal is the converse of consent,¹⁰ section 129 (2) of the Children's Act must surely sanction the right of a child to refuse medical treatment as well.¹¹ Therefore, drawing on section 129 (2) of the Children's Act, children may refuse medical treatment provided that they are sufficiently mature and have the mental capacity to understand the nature and effect of the refusal.¹² In addition, children must be sufficiently mature to understand the risks, obligations and other implications of the refusal of medical treatment.¹³ In other words, children must be competent to refuse medical treatment. Although competent children have the right to refuse medical treatment, this refusal may be overridden.¹⁴

1.4. Competent children should be entitled to the same rights that are afforded to adults

Section 7 (1) of the Constitution states:

‘[The] 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.’

A similar provision found in the Universal Declaration of Human Rights (henceforward referred to as the ‘UDHR’) states that, ‘all human beings are born free and equal in dignity and rights.’¹⁵

These provisions affirm that children equally possess and are entitled to enjoy the rights that adults possess and enjoy.¹⁶ The consequence of these provisions is that decisions made by children who are competent to make decisions must be afforded the same respect as decisions made by competent adults. Adults, provided that they are competent, make decisions without

¹⁰ C Lemmens ‘End-of-life decisions and minors: Do minors have the right to refuse life preserving medical treatment? A comparative study’ (2009) *Medicine and Law* 479.

¹¹ D J McQuoid Mason ‘Can children aged 12 years or more refuse lifesaving treatment without consent or assistance from anyone else?’ (2014) 104 (7) *SAMJ* 467.

¹² *Ibid.*

¹³ D J McQuoid Mason ‘The National Health Act and refusal of consent to health services by children’ (2006) 96 (6) *SAMJ* 531. Although the author refers to section 39 (4) of the Child Care Act 74 of 1983 in this article, the same can be said to apply to the provisions of section 129 (2) the Children's Act 38 of 2005.

¹⁴ *Ibid.*

¹⁵ Article 1 of the Universal Declaration of Human Rights, 1948, GA Resolution 217A (III).

¹⁶ I Currie & J De Waal *The Bill of Rights Handbook* 5th ed 2005 600.

fear of them being overruled. It is only when adults prove to be incompetent that decisions made by them are overruled or made by a third party.¹⁷ It is submitted that the same rules must apply when faced with decisions made by children, in particular, when faced with refusals of medical treatment by children. As long as children display competence to refuse medical treatment, such refusal must be respected without being overruled. Refusals made by children who display insufficient competence, however, may be overruled or consented to by third parties. However, considering that the position of the refusal of medical treatment by children has not been set out with clarity in South African law, section 39 of the Constitution stipulates that foreign law must be considered in order to develop South African law.

1.5. Foreign case law

International human rights conventions have encouraged the drafters of our Constitution by providing a powerful source of direction.¹⁸ In addition, foreign laws have also paved a steady path of inspiration for our Constitution and these provisions reverberate throughout the Bill of Rights.¹⁹ It is for this reason that our Constitution makes it obligatory for courts and tribunals as well as forums to consider international law when interpreting the Bill of Rights.²⁰ Furthermore, the Constitution provides the option to courts, tribunals and forums to consider foreign law, if the situation calls for such consideration, without making it compulsory.²¹ Due to the lack of South African legislation and case law concerning the refusal of medical treatment by children, it is submitted that international conventions and foreign cases dealing with this issue must be considered in order to develop South African legislation regarding a child's refusal of medical treatment.

¹⁷ Section 7 of the National Health Act 61 of 2003.

¹⁸ L Oette *Criminal Law Reform and Transitional Justice: Human Rights Perspectives for Sudan* (2013) 140. In respect of the rights of children, these influential international conventions include the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, which were ratified by South Africa on June 16th, 1995 and January 7th, 2000 respectively.

¹⁹ Ibid.

²⁰ Section 39 (1) (b) of the Constitution. See Oette (note 96 above; 140).

²¹ Section 39 (1) (c) of the Constitution.

1.6. Aims and objectives

This dissertation focuses on the competence of children to refuse medical treatment. It is submitted that the age of a child should not form part of the test of maturity that is used to determine whether or not children are competent to refuse medical treatment. Competence should be the only requirement to be satisfied when faced with the question of whether or not to override a refusal of medical treatment by a child. It is further submitted in this dissertation that refusals of medical treatment by children should be respected and upheld provided that the children making such refusals are competent to do so. It is submitted, therefore, that children must be afforded rights on an equal level as those of adults. This submission means that, similar to that of adults,²² a refusal of medical treatment by a child should only be overridden if the child is incompetent to make such refusal.

It will be shown that overruling the refusal of medical treatment by competent children would result in the violation of their rights. In this dissertation, each chapter will identify which rights of the child are violated, as well as the manner in which these rights are infringed, by disallowing a refusal of medical treatment by children. The infringements of these rights serve as reasons why decisions to refuse medical treatment by children are worthy of respect and fulfillment.

Although there may be a spectrum of other rights affected by overruling a competent refusal of medical treatment by a child, this dissertation will focus on a selected few. The following list represents some of the rights of children that are infringed by overruling their right to refuse medical treatment and will be discussed by each chapter respectively:

²² S Elliston 'If You Know What's Good For You: Refusal of Consent to Medical Treatment by Children' in S A M McLean (ed) *Contemporary Issues in Law, Medicine and Ethics* (1996) 42.

1. The right of children to express their views.
2. The right to refuse medical treatment based on competence rather than age.
3. The right to bodily and psychological integrity.
4. The right of children to be ‘treated’ in accordance with their best interests: What is really in the best interests of children?
5. The right to refuse medical treatment on religious grounds.

The contribution that is hoped to be made by this dissertation is as follows:

1. Children do have the right to refuse medical treatment; however it is not enough that this right be inferred from another right. The right of children to refuse medical treatment must be clearly provided for by the Children’s Act.
2. In clearly making provision for the right to refuse medical treatment in the Children’s Act, the age limit of 12 years that must be met in order to exercise the right to consent to (and therefore, to refuse) medical treatment must be removed. It is recommended that the Children’s Act adopt a ‘maturity based’ approach when determining whether a child has the competence to refuse medical treatment. Age should not form part of the test to determine whether children are competent to refuse medical treatment. The test should only be one of competence, involving an assessment of the maturity of a child to refuse treatment. Two principles of assessing maturity will be recommended.
3. A test to assess the maturity and competence of a child to refuse medical treatment must be developed and the correct professional responsible for making this determination must be identified.
4. Once a child has displayed sufficient maturity and competence to refuse medical treatment, this refusal of medical treatment must be respected and upheld. This submission is based on the practice followed when faced with the competent decisions made by adults. Competent children must be afforded the same rights as adults and considering that the only instance where adults are prohibited from making decisions by themselves is when they are incompetent, the same rule must apply to children. A refusal of medical treatment should only be disallowed if such refusal is expressed by an incompetent child.

5. Overruling a competent refusal of medical treatment by a child would infringe his or her:
 - 5.1. Right to express his or her views and participate in matters affecting him or her in terms of section 10 of the Children’s Act and Article 12 of the CRC;
 - 5.2. Right to bodily and psychological integrity in terms of section 12 of the Constitution and Article 8 of the European Convention on Human Rights;
 - 5.3. Right to be treated in accordance with his or her best interests according to section 28 (2) and section 9 of the Constitution and the Children’s Act respectively, as well as international and regional human rights conventions;
 - 5.4. Right to dignity as provided for by section 10 of the Constitution;
 - 5.5. Right to life as prescribed by section 11 of the Constitution;
 - 5.6. Right not to be treated or punished in a cruel, inhuman or degrading way as stated by section 12 (1) (e) of the Constitution;
 - 5.7. Right to freedom of religion, belief and opinion in terms of section 15 of the Constitution.

1.7. Chapter Outline

The United Nations Convention on the Rights of the Child, the Children’s Act, and numerous other influential sources provide children with the opportunity to voice their opinions and express their views. Chapter two will examine the right of children to express their views and have these views considered. It is submitted that the refusal of medical treatment is a view that children have a right to express. It is submitted further that the views of children must be respected and upheld, irrespective of whether these views express refusals of medical treatment. The views expressed by a child should be considered in accordance with the child’s maturity and stage of development.²³ Therefore, it is submitted, that refusals of medical treatment expressed by competent children must be respected and fulfilled. To disregard these views would infringe upon the rights of competent children to express their views and have such views taken seriously.

A child may consent to his or her own medical treatment if the child is over the age of 12 years, of sufficient maturity and has the mental capacity to understand the benefits, risks, social and

²³ Section 10 of the Children’s Act 38 of 2005.

other implications of the treatment.²⁴ By implication, this means that a child must be over the age of 12 years in order to refuse medical treatment. The child must also be sufficiently mature and have the mental capacity to understand the benefits, risks, social, and other implications of the refusal of medical treatment. The argument submitted is that irrespective of age, children should be allowed to consent to and refuse medical treatment as long as they are of sufficient maturity and have the necessary mental capacity to fully understand the benefits, risks and effects of such medical treatment. This is because it is of little value to proceed on the assumption that the mind of a child matures and develops as slowly as the body. Chapter three will show that there is no link between competence and age and that competence to refuse medical treatment can only be determined by assessing the child's maturity. Cases and principles from foreign jurisdictions will be discussed in order to support this submission. Foreign law concepts including the 'mature-minor' doctrine and 'Gillick competence' will be discussed in order to illustrate that once a child is sufficiently mature, competence to refuse medical treatment would be proven. Once a competent child has refused medical treatment, such refusal should not be overridden and the refused medical treatment should not be enforced against the child's will. To do so would violate the right of a competent child to refuse medical treatment. Chapter three will also deal with the fact that whilst legislation requires a child to be 'sufficiently mature,' it provides no test by which to make this determination. The importance of a child's maturity level and comprehension of medical treatment have been a recurring issue that has been dealt with by the courts.²⁵ The research undertaken emphasizes the importance of the maturity and understanding of the child, but fails to prescribe how these characteristics should be evaluated. There is no systematic approach, neither is there a specific test or analysis mentioned in any of these sources.²⁶

Everyone has the constitutional right to bodily and psychological integrity. This includes the right to security in and control over one's body and the right not to be subjected to medical experiments without one's informed consent.²⁷ This right further encompasses the right to autonomy and self-determination. Children are as equal bearers of this right as their adult

²⁴ Section 129 (2) of the Children's Act 38 of 2005.

²⁵ C E Burden-Osmond 'When Children Refuse Medical Treatment: Role of Governments and Assessments' (2002) 69 Def. Counsel J. 211.

²⁶ Ibid.

²⁷ Section 12 (2)(b) and (c) of the Constitution of the Republic of South Africa, 1996.

counterparts.²⁸ This right entails making autonomous decisions regarding one's body and provides protection against unauthorized intrusions against one's person.²⁹ Children are presumed to lack autonomy to make decisions regarding a refusal of treatment.³⁰ It is submitted that once such presumption has been rebutted, the right of a child to make autonomous refusals of medical treatment will be confirmed. This will allow children to exercise their rights to bodily and psychological integrity by refusing medical treatment. It is submitted that the effect of disallowing refusals of medical treatment by children effectively violate their rights to bodily and psychological integrity. Chapter four will involve an analysis of this constitutionally guaranteed right as everyone has the right to determine their own fate and to determine what happens to their own bodies. It is submitted that the application of this right should not cease at the mere mention of a child who wishes to refuse medical treatment. Children should be afforded protection against unwanted medical treatment by exercising their rights to bodily and psychological integrity.

The Constitution assures the importance of considering the best interests of children by stating that the 'best interests of the child are of paramount importance in every matter concerning the child.'³¹ The Children's Act also guarantees that the best interests of the child will be a paramount consideration in all matters concerning the care, well-being and protection of the child.³² It has been common practice for parents and courts to overrule refusals of medical treatment by children if it is considered to be in their best interests to do so.³³ Chapter five will involve a critical analysis of the 'best interests of the child standard' as a particular medical intervention, although life-saving, may not always be in the child's best interests. This will depend on the risks, implications and the degree of discomfort and pain that the child has already experienced. Certain medical treatment may result in adverse and crippling effects and may quicken the chances of fatalities years after the treatment. In other words, these treatments cause more harm than good and are not considered as being in the child's best interests merely because

²⁸ du Plessis, Govindjee, van der Walt op cit note 4 at 3.

²⁹ H Biggs *Euthanasia, Death with Dignity and the Law* (2001) 95.

³⁰ R G Hartman 'Adolescent Decisional Autonomy for Medical Care: Physician Perceptions and Practices' (2001) 8(1) *The University of Chicago Law School Roundtable* 88.

³¹ Section 28 (2) of the Constitution of the Republic of South Africa.

³² Section 9 of the Children's Act 38 of 2005.

³³ McQuoid Mason (note 11 above; 467).

it provides temporary relief. Often medical interventions compromise one's dignity and other constitutional rights as it may subject a child to extreme dependency during the prime of their childhood.³⁴ This would leave unchangeable effects to be endured throughout what has been left of their lives, if they have not already succumbed to the harmfulness of their medical treatment. It is submitted that compelling a competent child to undergo unwanted medical treatment that does not offer much benefit for him or her, is not in the best interests of the child.

A number of people lead lives that are firmly grounded on their religious beliefs and practices and in so doing are merely putting their constitutional right to the freedom of religion, belief and opinion to work.³⁵ However, when this right conflicts with the right of a child to consent to and refuse medical treatment, the result could be fatal. Religious credence often prevents a child from consenting to medical treatment and thus, is coerced into refusing what could sometimes be regarded as life-saving medical treatment. In other circumstances, children themselves wish to refuse medical treatment prohibited by their religious beliefs. It is submitted that children who are competent enough to understand the nature, risks and consequences of their refusal of medical treatment should not be prevented from carrying out their wishes and fulfilling their religious obligations. This will be the focus of Chapter six.

The abovementioned chapters will form the basis of the discussion, with Chapter seven providing the concluding remarks and recommendations.

1.8. Conclusion

It should not be automatically assumed that children lack capacity to refuse medical treatment based on their age. The capacity to refuse medical treatment depends on one's maturity and competence to understand the nature, risks and consequences of a refusal of medical treatment. Hence, refusals of medical treatment by children who are competent to understand the nature and consequences of their refusal must be respected. These refusals should not be overruled by parents, courts or other third parties. Once competence of children have been proved, there is no

³⁴ Ibid.

³⁵ Section 15 of the Constitution of the Republic of South Africa.

further reason why their decisions, and in particular their right to refuse medical treatment, should not be upheld and respected.

It will be shown, in the following chapters, that overriding competent refusals of medical treatment expressed by competent children would infringe their rights. It is recommended that children be afforded the same platform as adults provided that they are sufficiently mature and are capable of comprehending the seriousness of their situation. This recommendation has been made by considering the fact that a decision made by an adult will be respected unless the adult is incompetent to make the decision in question. The submission made in this regard is that refusals of medical treatment made by children should only be overruled if they are incompetent to make such refusal.

CHAPTER TWO

The Right of Children to Express their Views

2.1. Introduction

‘Participation’ has been defined as the process of being involved in decision-making that concerns oneself as well as the life of the community within which one resides.³⁶ It incorporates having a ‘voice’, which entails exercising control over processes, with having a ‘choice’ which allows one to control the decision being made.³⁷ Apropos of children’s rights, the right to participate embodies the right of children to partake in processes that affect their lives and the right to be heard.³⁸ It has been argued that a child’s participation in society begins as soon as the child is born into the world by his or her ability to influence the events that unfold in his or her life by their cries, actions and movements.³⁹ Although one cannot help acknowledging the broadness of this statement, one must consider the truth that it holds. While these are early interactions, such interactions are paid heed to; thus, children discover the influence that their voices have upon their lives and these interactions are seen as their way of ‘participating.’⁴⁰

Participation lies at the very core of a democratic nation and constitutes the means by which a democracy is achieved.⁴¹ Participation, therefore, is the fundamental right of all human beings.⁴² That being said, the UDHR asserts that all human beings are born free and equal in dignity and rights,⁴³ confirming that children must be granted the right to actively participate in decisions pertaining to their lives as well as the right to be heard in a manner comparable to that afforded

³⁶ R Hart ‘Children’s participation: From tokenism to citizenship’ (1992) *UNICEF* 5.

³⁷ A Moyo ‘Child participation under South African law: Beyond the Convention on the Rights of the Child?’ (2015) 31 *SAJHR* 173.

³⁸ *Ibid.*

³⁹ Hart (note 36 above; 4).

⁴⁰ *Ibid.*

⁴¹ *Ibid* at 4-5.

⁴² *Ibid* at 5.

⁴³ Article 1 of the Universal Declaration of Human Rights, 1948, GA Resolution 217A (III).

to adults. Consequently, children should be permitted to indulge in the four levels of participation (provided that they are competent to do so) which begins with the right to be informed about a decision that is to be made; being engaged with in order to express a view; provided with opportunities to influence outcomes; and making decisions independently which includes rebuffing a decision made by others.⁴⁴ The United Nations Convention on the Rights of the Child (henceforth referred to as the ‘CRC’) and the Children’s Act have recognised the necessity to create universal rights for children, in accordance with the stipulations proclaimed by the UDHR, to express their views and have these views considered.⁴⁵ In light of the provisos contained in these documents, it will be submitted that the right of the child to express their views and have their views respected must be observed in the context of medical law when children refuse medical treatment. Moreover, it will be submitted, that this refusal that children have the right to express, must be respected as is a refusal expressed by an adult.

2.2. The United Nations Convention on the Rights of the Child

The notion that children are not entitled to the same rights afforded to adults⁴⁶ as they are mere objects of another’s control and in need of protection from undue involvement in the deliberation of significant decisions⁴⁷ has been eradicated by the dawn of the CRC. The objectives of the CRC seek to ensure that competent children enjoy their rights at an equal level of fulfillment as adults.⁴⁸ With this in mind, Article 12 of the CRC was drawn, which declared that children who are capable of forming their own views, must be assured by State Parties, of their right to express their views freely in all matters affecting them, and that due weight must be attached to these views in accordance with the child’s age and maturity.⁴⁹ The absence of a prescribed age limit by

⁴⁴ G Lansdown ‘Promoting children’s participation in democratic decision-making (2001) *UNICEF* 16.

⁴⁵ R Stern ‘The child’s right to participation – Reality or rhetoric?’ (2006) *University of Uppsala* 13.

⁴⁶ *Ibid.*

⁴⁷ Hart (note 36 above; 5).

⁴⁸ Stern *op cit* note 35 at 14, where statistics were taken from UNICEF, a report called ‘The State of the World’s Children 2005: Childhood under threat’.

⁴⁹ Article 12 of the United Nations Convention on the Right of the Child. Ratified by South Africa on June 16th, 1995. The CRC also proceeds to state that a child shall, in particular, be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law. Judicial intervention is commonly sought when faced with a refusal of medical treatment by a child. The Article makes provision for such situation and ensures that a child will not be intimidated by judicial proceedings thereby discouraged from

which to attain in order to express views implies that children do not develop capabilities to form views once they reach a certain age. Rather, children become capable of forming their own views and opinions once they develop sufficient maturity.⁵⁰ This argument will be dealt with extensively in chapter three. The position that children make competent decisions based on maturity rather than age is now confirmed by Article 12 of the CRC. Children, once competent and capable, are able to form views even if they have attained competence at an early age.⁵¹

The Article demands the recognition of children as autonomous individuals⁵² and is indicative of the fact that there is an obligation to ensure that children are involved in matters affecting them where they will receive the opportunity to express their wishes and have these wishes considered according to the maturity that they displayed when reaching the decision.⁵³ It is, therefore, asserted that competent and capable children, who express their views in healthcare,⁵⁴ even when such views take the form of a refusal of medical treatment, such views must be considered and fulfilled alike to those expressed by an adult. It is further submitted that children who express views of this nature should not be coerced into changing their views in order to succumb to medical treatment as the Article protects children from this common situation by stating that children have the right to express their views ‘freely.’⁵⁵ The word ‘freely’ guards against coercion or constraint by parents that may prevent expression of the view to refuse medical treatment.⁵⁶ Therefore, parents may not compel children to undergo medical treatment that has been expressly denied by a competent child. The dispensation of medical treatment is a matter which directly affects the child concerned, about which the child is permitted to express his or her views which is worthy of consideration and fulfillment. A competent child cannot be envisaged and treated as subjects of higher authority⁵⁷ in need of extensive protection⁵⁸ whom are required to succumb to the decisions made by others on their behalf. Competent children in

expressing his/her views. See R Hodkin & P Newell ‘Implementation handbook for The Convention on the Rights of the Child’ *UNICEF* 156.

⁵⁰ Hodkin & Newell op cit note 49 at 153.

⁵¹ Stern op cit note 35 at 16.

⁵² Ibid at 15.

⁵³ Hodkin & Newell op cit note 49 at 153.

⁵⁴ Ibid at 155.

⁵⁵ Ibid at 155.

⁵⁶ Ibid.

⁵⁷ Ibid.

⁵⁸ Stern op cit note 45 at 15.

compliance with this Article cannot be deprived of this right unless they, in fact, do not satisfy the provisions of this Article. In other words, children who lack competence to express their views, lack competence to refuse medical treatment and cannot exercise this right.⁵⁹ A deprivation of this right should only be tolerated in this circumstance.

Considering these provisions, Article 12 of the CRC recognises the individuality of a child, as a person in his or her own right, with the ability to exercise control over his or her own life. When a child takes this entitled control over his or her life, the decision must be respected, notwithstanding the fact that the decision is a refusal of medical treatment.

2.3. The Children's Act 38 of 2005

The influence that Article 12 of the CRC has had on the authorship of the Children's Act is apparent by section 10 of the Act, which governs child participation in South Africa. By virtue of this section, a child, whom is of such an age, maturity or stage of development, so as to enable participation in any matter concerning the child in question, has the right to participate in an appropriate way and views expressed by the child must be given due consideration. Child participation endorsed by this section is a central theme of the Children's Act, as provisions of the like resonate throughout the Act. A similar provision has been found under section 31 of the Children's Act, which states that a person holding parental responsibilities and rights in respect of a child who takes any decision involving the child which is likely to significantly change, or have an adverse effect on, the child's living conditions, health, or well-being, must give due consideration to any views or wishes expressed by the child, taking into consideration the child's age, maturity and stage of development. By endorsing child participation, these provisions challenge the stereotypical belief that children are 'mere dependents' or 'property' incapable of autonomous choice thus, requiring protection and conversely, elevate children as equal bearers of rights to decide their fate.⁶⁰ The right to child participation identifies that children occupy a

⁵⁹ Hodkin & Newell op cit note 49 at 153.

⁶⁰ Moyo op cit note 37 at 174.

separate personhood from their parents and consequently, have a separate ‘voice’ that must be heard and considered in all matters affecting them.⁶¹

In medical law, it is submitted, that children must reap the benefit of the rights sanctioned by section 10 of the Children’s Act. Once a child has acquired sufficient competence to enable him or her to participate in healthcare decisions (decisions which intimately, gravely and possibly fatally, concern the child, thus qualifying as a ‘matter concerning the child’ in terms of section 10) the child has a right to participate and express views that deserve consideration. Whether the views express a child’s refusal of medical treatment matters not to the application of this right as the view must be given due consideration. It is submitted that being the view of a competent child, such a view must be respected and free from fears of being overruled.

Prior to the inception of the Children’s Act, when section 10 had not yet been in force, courts had decided cases based on the starkly similar principles found in Article 12 of the CRC. One such case was *Lubbe v Du Plessis*⁶² where Van Heerden J, in applying Article 12 of the CRC, held that ‘a court should give serious consideration to a child’s expressed preference and not lightly give an order which overrides this.’⁶³ By implication, taking into account the similarities between the CRC and section 10 of the Children’s Act, this would mean that section 10 would be applied in the same way, stressing the need to seriously consider the views expressed by a child which cannot be overridden with ease. It is submitted that when applying this principle to settings involving a refusal of medical treatment by a child, such refusal must be taken seriously and therefore, upheld, as such refusals cannot be easily overruled.

2.4. Conclusion

The rights of children to express their views are provided in the CRC and the Children’s Act. The provisions contained in these documents indicate that the rights of children to express their views are central to children’s rights.

⁶¹ Ibid.

⁶² (2001) 4 SA (C) 57.

⁶³ *Lubbe supra*.

Article 12 of the CRC declares that State Parties shall assure, a child who is capable of forming his or her own views, of his or her right to express those views freely in all matters affecting him or her. The convention further states that these views must be given due weight in accordance with the age and maturity of the child.⁶⁴ The Article does not stipulate a certain age that children must attain before their views can be considered. According to the Article, once children are capable of forming their own views, they have a right to express those views and have those views considered to their maturity and age. This implies that the only requirement to satisfy in order for children to have their views considered is that children must be competent to express their views. It is submitted that in medical law, when competent children express their views of refusals of medical treatment, such refusals must be respected and upheld. This must be done as long as the child in question displays sufficient maturity and competence to understand the nature and the effect of his or her refusal. Competent children who satisfy the requirements of Article 12 cannot be deprived of this right, unless they lack competence to express their views. Once children lack competence to express their views, they lack competence to refuse medical treatment. Competent children, on the other hand, do not lack the competence to express their views. Such children must be allowed to express their refusals of medical treatment and have these views respected.

Section 10 of The Children's Act governs child participation in South Africa. According to this section, a child whom is of such an age, maturity or stage of development, so as to enable participation in any matter concerning the child in question, has the right to participate in an appropriate way and views expressed by the child must be given due consideration. This section confirms that children have the right to express their views provided that they are sufficiently mature and competent to do so. Children are recognised as being 'separate persons' from their parents and thus, have an independent voice that must be heard. It is submitted that these principles must be applied in a medical law context when children refuse medical treatment. Children who are sufficiently mature and competent to understand the consequences of their refusal of medical treatment must be allowed to express these views and have these views considered.

⁶⁴ Article 12 of the United Nations Convention on the Right of the Child. Ratified by South Africa on June 16th, 1995.

It is recommended that the terms of the provisions of the CRC and the Children's Act should be applied in the context of medical law when faced with a refusal of medical treatment by a child. Should such child satisfy the requirements of the Convention and the Children's Act, he or she must be able to express their refusals of medical treatment and have these views respected and upheld. In other words, the refusal of medical treatment is a view that competent children have the right to express.

CHAPTER THREE

The Right to Refuse Medical Treatment Based on Competence Rather Than Age

3.1. Introduction

The promulgation of the Children's Act sought to supplement and give effect to the rights that children already enjoy in terms of The Bill of Rights.⁶⁵ The provisions of the Children's Act aim further to provide children with the care, protection and safeguards that will ensure that their constitutional rights are being fulfilled, while their overall well-being is being promoted and strived for concurrently.⁶⁶ The Act governs a wide range of interests and rights that children are entitled to, including their right to consent to medical treatment.⁶⁷

Section 129 (2) of the Act allows a child to consent to their own medical treatment (or to the medical treatment of his or her child) if the child is over the age of 12 years and is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. Although it is a controversial issue about which many disagree with due to the lack of legislation governing the right of a child to refuse medical treatment, it is a shared belief by the majority that children who are competent and mature enough to consent to their own medical treatment in terms of section 129 (2) of the Act, are also competent and mature enough to refuse the very same medical treatment that they would have been permitted to consent to.⁶⁸ Informed refusal, therefore, is the counter-argument of informed consent. This

⁶⁵ The aims of the Children's Act are set out in the long title.

⁶⁶ du Plessis, Govindjee, van der Walt op cit note 4 at 7.

⁶⁷ Section 129 of the Act.

⁶⁸ M A Dada & D J McQuoid-Mason *A – Z of Medical Law* (2011) 425. See also D J McQuoid Mason 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse: 1 April 2010.' (2010) 100 (10) *SAMJ*.

chapter proceeds on the notion that consent encompasses refusal. Several countries do not draw a distinction between the right of a child to consent to or refuse medical treatment and proceed on the argument that once a child is deemed sufficiently mature, they should be afforded equal rights as those of adults whom are legally permitted to refuse medical treatment.⁶⁹ This settles the skepticism of whether or not children have a right to refuse treatment confirming that they indeed do. This chapter involves a discussion about section 129 (2) of the Children’s Act with the intention of discovering the bearing that it has on the right of the child to refuse medical treatment. It has been established that once an individual is allowed to consent to an act he should, in the same instance, be allowed to refuse consent to the same.

3.2. An analysis of section 129 (2) of the Children’s Act 38 of 2005

Section 129 (2) of the Children’s Act deals directly with the right of a child to consent to medical treatment and prescribes an age limit by which to attain in order to consent to medical treatment. Section 129 (2) states that:

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

The use of the word ‘and’ in section 129 (2) of the Children’s Act specifies that there is a compulsory requirement for the presence of both stipulated factors in order for a child to consent to, or refuse,⁷⁰ their own medical treatment. This means that a child must firstly, be at least 12 years of age and above and; secondly, be of sufficient maturity to understand the benefits, risks, social and other implications of the treatment. There is no ‘either/or.’ In other words, the Act

⁶⁹ *Cruzan v Director of Missouri Department of Health* (1990) 497 (US) 261.

⁷⁰ A Govindjee & J Malherbe ‘A question of blood: Constitutional perspectives on decision-making about medical treatment of children of Jehovah’s Witnesses’ (2010) (73) *THRHR* 72.

uses a ‘combined approach’ in order for a child to be eligible to consent to their own medical treatment.⁷¹ This approach poses a problem.⁷²

Acknowledging that this approach is an improvement on the age-based approach followed by the Child Care Act 74 of 1983,⁷³ the new combined approach creates an unnecessary assumption that all children below the age of 12 years automatically lack the capacity to consent to medical treatment without considering the tangible possibility that children below the age of 12 may well be sufficiently mature to consent to their own medical treatment.⁷⁴ This assumption of a lack of maturity drastically decreases the right of a child to make authoritative decisions regarding their health.⁷⁵ In consequence, holding the view that all children below the age of 12 are not sufficiently mature, and then proceeding to enact it in terms of section 129 (2), possibly restricts a child’s autonomy.⁷⁶ It places an underestimation on the ability of a child to participate in major health decisions even when they are capable of doing so.⁷⁷ Age does not determine maturity nor does it mechanically confer capacity on a child to consent.⁷⁸ In simple terms, age does not bring maturity. One must be cognisant of the fact that there may be instances in which a child below the age of 12 years may be sufficiently mature to consent to his or her own medical treatment, whereas a child who finds him or herself within the bounds of the age requirement may not be sufficiently mature to provide consent.⁷⁹

The ‘combined approach,’ as discussed above, appears to be stringent and overly protective of children.⁸⁰ Although this approach was introduced for understandable reasons, for the protection of the child from poorly-made health decisions, it limits respect for the child’s autonomy.⁸¹ The reason why a poorly-made decision has been made in the first place is due to the lack of maturity of the child. The presence of which must be established in the affirmative before the decision can

⁷¹ du Plessis, Govindjee, van der Walt op cit note 4 at 11.

⁷² Ibid.

⁷³ Ibid. See section 39 (4) of the Child Care Act 74 of 1983.

⁷⁴ J Sloth-Nielsen in C J Davel & A Skelton (eds) *Commentary on the Children’s Act 38 of 2005* (2008) Juta 19 (3).

⁷⁵ T Boezaart *Child Law in South Africa* (2009) 214.

⁷⁶ L Reynolds ‘Consent and competence in paediatrics.’ (2007) *IJCR* 503.

⁷⁷ Ibid.

⁷⁸ du Plessis, Govindjee, van der Walt op cit note 4 at 22.

⁷⁹ *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T) Global Health and Human Rights Database 1.

⁸⁰ Boezaart (note 75 above; 214).

⁸¹ Ibid.

be made in order to avoid a disparaging decision. Children do not make unfortunate decisions as a result of their age alone. This principle has been encapsulated in the case of *Gillick v West Norfolk and Wisbech Area Health Authority*,⁸² as will be discussed later in this chapter, where Lord Scarman had declared that a minor's capacity to make his or her own decision is dependent upon the minor having a sufficient level of understanding and intelligence to make that decision for him or herself.⁸³ The court had agreed that a minor's capacity to make a decision 'is not to be determined by reference to any judicially fixed age limit.'⁸⁴

Correspondingly, in the case of *Christian Lawyers Association v Minister of Health*,⁸⁵ the court noted that informed consent depended on capacity.⁸⁶ The court proceeded to comment on the notion of a fixed age requirement to satisfy before one is eligible to provide informed consent and stated that:

'The plaintiff's approach is a rigid approach to maturity which is blind to the fact of life that there will be women below an age who are in fact mature, much as there will be those above that age (or any fixed age) who are in fact immature. It fails to recognise and accommodate individual differences.'⁸⁷

The above submission endorses that informed refusals depend on capacity and cannot come into existence upon reaching an irrationally prescribed age. Impositions of strict age limits have received discouraging remarks, in particular, from the CRC where there is a lack of an age limit found in Article 12.⁸⁸ As discussed in chapter two, this confirms that the Convention provides 'no support to those who impose a strict age limit on the right of a child to express his or her

⁸² (1986) AC (HL) 112. This case will be discussed in greater detail as the chapter progresses.

⁸³ *Gillick supra* at 188.

⁸⁴ *Gillick supra*.

⁸⁵ 2004 (10) BCLR 1086 (T).

⁸⁶ *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR 1086 (T) Global Health and Human Rights Database 1.

⁸⁷ *Ibid*.

⁸⁸ Article 12 of the United Nations Convention on the Right of the Child states that children who are capable of forming their own views, must be assured by State Parties, of their right to express their views freely in all matters affecting them, and that due weight must be attached to these views in accordance with the child's age and maturity.

views and to have these views considered.’⁸⁹ This supports the view that a strict age limit cannot be imposed on the right of children to consent to and refuse medical treatment.

There are a number of authors, scholars and academics who are in agreement about the view that there should not be a ‘combined approach’. The suggestion put forward is that an approach which focuses on maturity rather than age is preferred.⁹⁰ This is so because the maturity and development of children differ greatly from child to child; as inferred, a strict age requirement cannot be applied to a problem that requires subjective testing. It is recommended that an assessment of competence to refuse medical treatment should be based on the level of maturity possessed by the child concerned. It is submitted that age should not form the basis of a test of competence.

3.3. Maturity as the preferred test of competence: Adopting the Mature Minor Doctrine

Maturity is the ability to comprehend, understand and assess the implications of a particular matter.⁹¹ More importantly, maturity is the ability to understand the nature of medical treatment and the risks that follow as well as the consequences of refusing it. Once this has been established, there is no other reason why a refusal made by a mature minor should not prevail. It certainly should not cease to carry forward on the basis of the child’s age.

The Choice on Termination of Pregnancy Act 92 of 1996 (hereafter referred to as the ‘Choice Act’) provides a good indication that age is not a prerequisite for an astute decision to be made, by conferring decisional autonomy on a pregnant minor to terminate her pregnancy irrespective of her age. The Choice Act directs that a pregnancy may be terminated upon request by a woman⁹² whom is defined by the Act as being ‘any female person of any age.’⁹³ The Choice Act makes no mention of any age limit burdened upon any woman who wishes to terminate her

⁸⁹ Hodkin & Newell op cit note 49 at 153.

⁹⁰ *Gillick* supra note 82 at 188.

⁹¹ Committee on the Rights of the Child, General Comment 12, para 30.

⁹² Section 2 (1) (a) of the Choice Act.

⁹³ Section 1 of the Choice Act.

pregnancy, confirming that all woman, of all ages, are permitted to terminate their pregnancies if they so wish. The only notable circumstances in which a woman would not be able to request and consent to a termination of pregnancy, thus requiring the request and consent of the woman's natural guardian, spouse, legal guardian or *curator personae*,⁹⁴ is if the woman is found to be in one of two situations. The first situation involves the woman being so severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of the termination of her pregnancy.⁹⁵ The second situation is if the woman is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and consent to the termination of her pregnancy.⁹⁶ These two situations are the only situations in which a woman will not be able to request and consent to a termination of pregnancy. This clearly indicates that age is completely excluded as one of the situations in which a woman would not be competent to request or consent to a termination of pregnancy. This confirms that requesting and consenting to a termination of pregnancy does not depend on age.

It is evident that the Choice Act does not adopt an age-based approach requiring a woman to be of a certain age in order to request and consent to a termination of pregnancy and merely requires a female minor to provide her informed consent to the termination of her pregnancy on condition that she is capable of doing so.⁹⁷ Hence, it is submitted that section 129 (2) of the Children's Act should ideally follow suit and allow a child, regardless of age, to consent to and refuse consent to medical treatment as long as they are competent and capable of doing so.

A number of countries allow children of any age to acquire rights of consent to and refusal of medical treatment if the child can show 'sufficient understanding' of what is being consented to or refused.⁹⁸ One such example is British Columbian Law which has a provision which states that a child may consent to his or her own medical treatment on condition that he or she understands the nature, consequences and the reasonably foreseeable benefits and risks of the

⁹⁴ Section 4 (i) – (ii) of the Choice Act.

⁹⁵ Section 4 (a) – (b) of the Choice Act.

⁹⁶ Choice Act *supra*.

⁹⁷ DJ McQuoid Mason 'Some consent and confidentiality issues regarding the application of the Choice on Termination of Pregnancy Act to girl-children' (2010) 3 (1) *SAJBL* 13.

⁹⁸ Boezaart (note 75 above; 213-214).

medical treatment.⁹⁹ Such consent is effective and once acquired, renders it unnecessary to obtain consent to the medical treatment from the infant's parent or guardian.¹⁰⁰ The Infants Act (RSBC 1996) duly follows a maturity approach and does not stipulate a mandatory age by which children may consent to or refuse medical treatment.

The Canadian Supreme Court was faced with a case which required them to review legislature which did not allow a child under the age of 16 to make an authoritative decision concerning medical treatment.¹⁰¹ The matter was taken to court by a child of 14 years of age who had refused a blood transfusion because it was contrary to her religious beliefs.¹⁰² In analyzing the maturity of the child, the court concluded that the best approach to the issue was to allow a child under the age of 16 to lead evidence of *maturity*.¹⁰³ Justice Abella held that by permitting children under 16 to lead evidence of sufficient maturity to determine their medical choices, their ability to make decisions regarding their medical treatment is 'ultimately calibrated in accordance with maturity, not age';¹⁰⁴ therefore, no disadvantaging prejudice or stereotype based on age was employed nor was it needed.¹⁰⁵ The court in this case abandoned the idea of an assessment of maturity based on the age of the child and focused on the actual maturity of the child for a more accurate evaluation.

A comparable approach had been adopted in the English case of *Gillick*,¹⁰⁶ where the House of Lords confirmed that a child who has 'sufficient understanding and intelligence to understand the nature and implication of the proposed treatment,' is permitted to consent to medical treatment independently of their parents, rendering the need for parental consent superfluous.¹⁰⁷ This case further displayed that the court did not restrict the capacity of a child to an age limit, but rather to the child's maturity.

⁹⁹ Chapter 223, Section 17 of the Infants Act (RSBC 1996).

¹⁰⁰ Infants Act *supra*.

¹⁰¹ *AC v Manitoba (Director of Child and Family Services)* (2009) SCC 30.

¹⁰² *AC supra*.

¹⁰³ *AC supra*.

¹⁰⁴ *AC supra*.

¹⁰⁵ *AC supra*.

¹⁰⁶ (1986) AC (HL) 112. See footnote 82 above.

¹⁰⁷ *Gillick supra*.

The above-mentioned legislation and case law support the common law doctrine existent in many countries that any minor who is mature and is able to sufficiently understand the nature of the proposed medical treatment is able to consent to and refuse consent to such treatment, without making the attainment of a certain age a necessity.¹⁰⁸ This doctrine has been termed the ‘Mature Minor’ doctrine, which is based on the principle that minors who display a sufficient level of maturity ought to have their decisions respected by others, irrespective of their age.¹⁰⁹ Such minors deserve to have their desires and preferences accorded a tremendous amount of weight as once they have been declared a ‘Mature Minor,’ they are considered to be a *de facto* adult who should be treated as a legal adult.¹¹⁰ This doctrine is supplemented by studies in child development which prove that children have the requisite competence and maturity to make informed autonomous choices which should be respected to the same degree as those of adults.¹¹¹ These informed autonomous choices require the presence of three capacities in order to make mature and competent decisions: capacities for communication and understanding of information; capacities for reasoning and deliberation and; capacities to have and apply a set of values.¹¹² These capacities are necessary in order to ensure that choices made by individuals are truly competent and mature autonomous choices that correlate with their perception of well-being.¹¹³ While adults are presumed to have this capacity, minors are presumed to lack the capacity to rise to the level of maturity required to make a competent autonomous decision.¹¹⁴

¹⁰⁸ Burden-Osmond (note 25 above; 212).

¹⁰⁹ JF Will ‘My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs’ (2006) 22 (2) *Journal of Contemporary Health Law and Policy* 236.

¹¹⁰ MT Harvey ‘Adolescent Competency and the Refusal of Medical Treatment’ (2003) *Health Matrix* 304.

¹¹¹ *Ibid.*

¹¹² These capacities were suggested by authors Allen E. Buchanan and Dan W. Brock in their book *Deciding For Others: The Ethics of Surrogate Decision Making* (1990) 23.

¹¹³ Buchanan and Brock identify that defining one’s conception of well-being is philosophically complex and provide three theories of well-being. Firstly, the Hedonist theory holds that having specific positive conscious experiences such as happiness and pleasure, are the only thing that is actually good for a person. Secondly, according to the Preference or Desire Satisfaction theory, having one’s desires or preferences satisfied to the maximum extent possible is what is considered to be good for that particular individual. Lastly, The Objective List or Ideal Theory denies the first two theories by stating that happiness and preference satisfaction are all that there is to personal well-being because there are things that will be considered to be either good or bad for a person irrespective of whether they are happy or have their aims and preferences satisfied. See Buchanan & Brock op cit note 112 at 31 – 33.

¹¹⁴ Will (note 109 above; 244).

There is a lack of empirical data in support of this presumption that children have an inability to reason, understand and communicate about the burden of medical decisions. The lack of evidence, however, should not automatically be assumed to be attributed to the inability of children to reason, understand and communicate their decisions about the refusal of medical treatment.¹¹⁵ Research proves that many children reach adult levels of competence and maturity (making them no less competent to consent to and refuse treatment than adults¹¹⁶) while they are still legally considered to be minors.¹¹⁷ Research also suggests that adults do not possess understanding and reasoning faculties that are superior to that of children;¹¹⁸ therefore, to assume that children lack the capacity to reason, understand and make mature decisions, without assessing the actual maturity of the child, is a colossal error. Research also suggests that adults do not possess understanding and reasoning skills that are superior to that of children. It is a further presumption that children have limited life experience¹¹⁹ which causes them to attach inadequate weight to the consequences and effects of their health care decisions and they may also fail to consider future changes in their values that may easily be predictable by their superiors.¹²⁰ Minors are alleged to place greater emphasis on the present rather than the future consequences of their decisions¹²¹ and are believed to engage in perilous risk-taking more often than adults.¹²²

All of these poor assumptions lend themselves to the misconception that all minors need to be protected from themselves and their decisions until the conception of well-being that will result in competent and mature decisions deserving of respect; in other words, until they reach adulthood.¹²³ While all of these presumptions may be true for *some* children, the same cannot be said for *all* children. One strict assumption cannot be applied as if all children are exactly the

¹¹⁵ Ibid.

¹¹⁶ Hartman (note 30 above; 88).

¹¹⁷ H Kruger 'Traces of Gillick in South African jurisprudence: Two variations on a theme' (2005) 46(1) *Codicillus* 1. See also SB Campbell & LA Weithorn 'The Competency of Children and Adolescents to Make Informed Treatment Decisions' (1982) 53(6) *Child Development* 1589.

¹¹⁸ Hartman (note 30 above; 88).

¹¹⁹ LF Ross *Children, Families and Health Care Decision Making* (1998) 61.

¹²⁰ Buchanan & Brock (note 112 above; 221)

¹²¹ AE Driggs 'The Mature Minor Doctrine: Do Adolescents Have the Right to Die?' (2001) *Health Matrix* 704.

¹²² LE Ponton *The Romance Of Risk: Why Teenagers Do The Things They Do* (1997) 1.

¹²³ Will (note 109 above; 245).

same as each other. Maturity is a subjective concept requiring subjective scrutiny¹²⁴ thereby; the only manner by which to determine whether a child is sufficiently mature to make competent decisions is to test their individual maturity according to the Mature Minor Doctrine. The doctrine simply states that if a child has sufficient competence to maturely make an autonomous decision, that decision should be respected without influence or interference by third parties.¹²⁵ This doctrine focuses on the fact that certain children are mature enough to comprehend the nature and extent of their medical conditions and make competent decisions regarding the same.¹²⁶ These children have the ability to consider the consequences and effects of their decisions which would ultimately be in accordance with their conception of well-being, thus obviating protection from their parents or healthcare practitioners.¹²⁷ These minors are sufficiently mature to know what is best for them, and should be allowed to carry out their decisions without hindrance.

3.4. Case law involving the Mature Minor Doctrine

The principles of the Mature Minor Doctrine have been invoked in many foreign law cases; however, this doctrine has not been applied to South African cases. The Mature Minor Doctrine has not been adopted in South Africa. Thus, the following cases reflect the position in other jurisdictions. The discussion below supplements the recommendation that the Mature Minor Doctrine should be incorporated into South African legislation in order to determine whether children are competent to refuse medical treatment.

Applying the Mature Minor Doctrine, foreign courts have appropriately instituted an individualized assessment of the maturity of minors to make decisions.¹²⁸ One such case which highlights this principle is *Wisconsin v Yoder*,¹²⁹ which involved conflict among three sets of Amish parents and the State of Wisconsin.¹³⁰ The Amish parents were convicted of violating the

¹²⁴ Boezaart (note 75 above; 212).

¹²⁵ RG Hartman 'Adolescent Autonomy: Clarifying an Ageless Conundrum' (2000) *HLJ* 1311.

¹²⁶ Will (note 109 above; 259).

¹²⁷ *Ibid.*

¹²⁸ Will (note 109 above; 262).

¹²⁹ (1972) 406 (US) 205.

¹³⁰ *Yoder supra* at 207.

State's compulsory education law which required children to attend public or private school until the age of 16. However, the parents had forcibly withdrawn their children from school after they had completed the eighth grade due to their religious beliefs.¹³¹ Justice Douglas suggested that if a child makes a decision and is mature enough to have this decision respected, even though it may differ from that of his or her parent, the State may well be able to override the decisions of third parties.¹³²

The Tennessee Supreme Court in *Cardwell v Bechtol*¹³³ were required to consider whether to adopt the Mature Minor Doctrine in respect of a minor whom had consulted with an osteopathic physician without her parents' knowledge.¹³⁴ The court reasoned that the Mature Minor Doctrine is to be applied according to the facts of each case and that whether a minor has the capacity to consent to medical treatment or not is dependent upon the child's degree of maturity, ability, experience, training, education, or upon the judgement obtained by the minor.¹³⁵ It further depends on the 'conduct and demeanor' of the child at the time of the event in question.¹³⁶ In its summation, the court stated that the totality of the circumstances must be considered, which includes the nature of the risks and consequences of the treatment concerned, as well as the ability of the child to appreciate those risks and consequences.¹³⁷ On this principle, the court concluded that the patient was a mature minor possessing the 'ability, maturity, experience, education and judgment...to consent knowingly to the medical treatment concerned.'¹³⁸ Although this case involved the right of the child to consent to medical treatment, as alluded to, the right of the child to consent, includes the right of the child to refuse medical treatment signifying that according to the Mature Minor Doctrine, a child who is mature enough to consent to treatment is equally mature to refuse treatment.

¹³¹ *Yoder supra* at 207.

¹³² *Yoder supra* at 242.

¹³³ (1987) 724 S.W.2d Tenn 739.

¹³⁴ *Cardwell supra* at 741 – 743. During the consultation, the healthcare practitioner had incorrectly excluded a herniated disc and ensued treatment through manipulations of the patient's neck, spine and legs. It later emerged, after developing bladder and bowel retention as well as diminished sensation in her legs and buttocks, that the patient indeed suffered from a herniated disc. The patient together with her parents charged the physician with malpractice for a misdiagnosis, failure to obtain parental consent, negligent failure to obtain consent and the failure to obtain informed consent.

¹³⁵ *Cardwell supra* at 748.

¹³⁶ *Cardwell supra*.

¹³⁷ *Cardwell supra*.

¹³⁸ *Cardwell supra* at 749.

The 1992 case of *Belcher v Charleston Area Medical Center*¹³⁹ involved a minor suffering from muscular dystrophy.¹⁴⁰ The issue facing the court was whether or not the minor should have been consulted prior to a formalization of a ‘Do Not Resuscitate’ order after the minor’s parents were asked to sign a progress note stating that the minor should not be reintubated or resuscitated in the event of a respiratory failure. In order to decipher this issue, the court had applied the ‘Mature Minor’ doctrine.¹⁴¹ The court held that the mature minor rule varies from case to case and focuses on the maturity level of the child as well as their capacity to appreciate the nature and risks of the medical treatment that is to be consented to or refused, confirming the right of the child to refuse treatment.¹⁴² The court assessed the minor’s maturity based on this doctrine and empowered mature minors who satisfied this doctrine to consent to or refuse medical treatment, despite their parents’ refusal.¹⁴³

Another case recognizing a minor’s right to refuse medical treatment and in favour of the Mature Minor Doctrine was the case of *In Re Swan*¹⁴⁴ where a minor, Chad, was maintained by life-sustaining treatment in the form of a gastrostomy tube which eventually eroded.¹⁴⁵ The consensus between the physicians and Chad’s parents were that the tube should not be reinserted. Furthermore, Chad’s mother had presented evidence to the court that her son would not have consented to the reinsertion either as he had expressed his wishes to ‘go in peace’.¹⁴⁶ The court rejected arguments by the State that Chad’s right to refuse medical treatment was ‘significantly reduced’ as he was under the age of majority at the time of expressing those wishes.¹⁴⁷ Instead,

¹³⁹ (1992) 422 S.E.2d 827.

¹⁴⁰ *Belcher supra* at 829 – 320. Larry Belcher was rushed to the emergency room where he suffered breathing failure which required him to be transferred to the paediatric intensive care unit to be intubated and placed on a respirator. The healthcare practitioner discussed with Larry’s parents the likelihood of him suffering another breathing failure and enquired about whether they wished for Larry to be intubated again in this event, to which his parents stated that unless requested by Larry, they did not want him to be reintubated or resuscitated. The practitioner had asked Larry’s parents to sign a progress note stating that Larry should not be reintubated or resuscitated in the event of another respiratory failure which was then formalized into a ‘Do Not Resuscitate’ order, without consulting Larry. The following day, Larry had died after going into cardiac failure after another respiratory arrest.

¹⁴¹ *Belcher supra* at 831.

¹⁴² *Belcher supra* at 838.

¹⁴³ *Belcher supra*.

¹⁴⁴ (1990) 569 A.2d 1202.

¹⁴⁵ *Swan supra* at 1202.

¹⁴⁶ *Swan supra* at 1205

¹⁴⁷ RA Hartman ‘Coming of age: Devising legislation for adolescent medical decision-making’ (2002) *AJLM* 30.

the court reduced the significance of Chad's age to a mere factor to consider when assessing the seriousness of his wishes;¹⁴⁸ the court, by no means, implied that Chad did not have a right to refuse medical treatment due to his age. The court upheld Chad's right to refuse treatment and concluded that his wishes were 'well-informed desires as to medical treatment' and should be respected.¹⁴⁹

Joshua Walker was a minor who had suffered from cancer and his treatment required blood transfusions – treatment that was in direct conflict with his religious beliefs as a Jehovah's Witness.¹⁵⁰ The New Brunswick Court of Appeal in *Walker v Region 2 Hospital*¹⁵¹ decided that Joshua was a mature minor who had the ability to understand the consequences of both receiving and not receiving medical treatment;¹⁵² resultantly, he was able to refuse medical treatment. A child who had suffered a similar fate to that of Joshua was found in the case of *RE A.Y.*,¹⁵³ where, after refusing blood transfusions that were contrary to religious beliefs, Justice Wells concluded that the child had a maturity level that far exceeded that of a 15 year old thereby allowing the child to refuse medical treatment.¹⁵⁴

In 1994, Billy Agrelo had undergone two liver transplants for which he took experimental anti-rejection drugs to prevent his body from rejecting the organs.¹⁵⁵ These drugs caused debilitating side effects to the point where Benny had refused to continue with the drugs, contrary to his parents and healthcare practitioner's advice.¹⁵⁶ Soon after, Benny's mother had made a decision to support his wishes – a decision which inspired a charge of neglect against her.¹⁵⁷ The court had held separate meetings with Benny, his doctors and his mother and had decided that Benny was sufficiently mature to make decisions for himself and prohibited any further infringements

¹⁴⁸ *Swan supra* at 1205.

¹⁴⁹ *Swan supra* at 1205-1206.

¹⁵⁰ *Walker v Region 2 Hospital* (1994) 4 R.F.L.

¹⁵¹ (1994) 4 R.F.L.

¹⁵² *Walker supra* at para 31, 42.

¹⁵³ (1993) 111 N.F.L.D. & P.E.I.R. 91.

¹⁵⁴ *A.Y. supra*.

¹⁵⁵ Hartman (note 125 above; 687).

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid* at 688.

of his wishes.¹⁵⁸ Benny passed on shortly after his success at court and became widely renowned as the mature minor who had the right to refuse life-saving medical treatment.¹⁵⁹

These cases were judged by the use of the Mature Minor Doctrine which allows mature children to make decisions worthy of respect. These cases do not attach importance to the age of children. Consequently, the first recommendation made in this chapter that the wording of section 129 (2) of the Children's Act be revisited and altered to eradicate the abovementioned 'combined approach' to solely require sufficient maturity of the child to understand the risks, social and other implications of the treatment in order to consent to or refuse medical treatment. Conceding that the drafters of this legislation must have included the age restriction of 12 years (although seemingly arbitrarily decided upon¹⁶⁰) for the sake of uniformity, the second recommendation made in this chapter is to change the wording of section 129 (2) to read, 'who by age *or* maturity'.¹⁶¹ This recommendation had also been made by the Children Right's Project and Local Government where even sufficiently mature children who have not yet attained the age of consent will be able to pursue their decisions.¹⁶² The second recommendation has been made if the first recommendation cannot be implemented. Adopting the approach of the 'mature minor' will allow for a more accurate subjective assessment, as these circumstances demand a case-by-case analysis.¹⁶³ This is attributed to the fact that research conducted and found by developmental psychologists recommend that age restrictions placed on children should constantly be reviewed, or preferably removed, as the legal capacity of children is a question of maturity and not of age.¹⁶⁴ When children are considered as 'mature', they evidently possess the

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ HH Foster & DJ Freed 'A bill of rights for children' (1972) 6 FLQ 345; MDA Freeman 'The limits of children's rights' in Freeman & Veerman (eds) *The Ideologies of Children's Rights* (1992) 34 – 35. Acknowledging that there seems to be general consensus that an age limit must be drawn somewhere, and that legislators and courts are not unreasonable while setting an average age requirement where a particular function is required, as long as the age set is not completely far-fetched from custom, it must be acknowledged, by the same token, that particular functions cannot successfully be performed in the midst of a strict age limit due to their very nature. Certain functions require subjective analysis where the imposition of an age limit is of very little use. See H Kruger 'Traces of *Gillick* in South African Jurisprudence: Two variations on a theme.' (2005) Vol 46 Issue 1 *Codicillus* 3.

¹⁶¹ *Review of the Child Care Act Report* 141.

¹⁶² Ibid.

¹⁶³ du Plessis, Govindjee, van der Walt op cit note 4 at 12.

¹⁶⁴ MDA Freeman *The Rights and Wrongs of Children* (1983) 22 – 23. See S Human 'The Theory of Children's Rights' in CJ Davel *Introduction to Child Law in South Africa* (2000) 157 – 158.

cognitive capability to understand, appreciate, reason and articulate their decisions equivalent to that of adults.¹⁶⁵ Another principle based on this reasoning is the principle of ‘Gillick competence’ which also endorses the use of a test of maturity to determine competence as opposed to the attainment of a certain age.

3.5. Maturity as the preferred test of competence: Adopting the principle of ‘Gillick competence’

As referred to above, the lack of legislation governing the right of children to refuse medical treatment calls upon the consideration of foreign cases. Of particular import in this ambiguous area of law is the case of *Gillick v West Norfolk and Wisbech Area Health Authority*,¹⁶⁶ a case that has contributed significant guidelines to legal systems in all jurisdictions of the world. This revolutionary case has coined the term ‘Gillick competence’, which is similar to the ‘Mature Minor Doctrine’ discussed above. It is submitted that the South African legal system would do well to adopt the principles that arise from the *Gillick* case.

The *Gillick* case involved a circular issued by the Department of Health and Social Security, during 1974, within which advice had been given to girls under the age of 16. The essence of this advice was that the decision to provide contraception to a girl under the age of 16 was one to be made by a doctor.¹⁶⁷ It provided relief for doctors who were consulted at family planning clinics by girls under the age of 16 years.¹⁶⁸ It stipulated that they were not acting unlawfully if they prescribed contraceptives for such girls provided that in doing so, the doctors had acted in good faith to protect such girls against the damaging effects of engaging in sexual intercourse.¹⁶⁹ It permitted doctors to lawfully treat and prescribe for a girl without contacting her parents, and stated that doctors should not contact a girl’s parents at all without her agreement.¹⁷⁰

¹⁶⁵ Hartman (note 125 above; 1285-1286).

¹⁶⁶ (1986) AC (HL) 112.

¹⁶⁷ Brazier & Cave op cit note 6 at 400.

¹⁶⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* (1984) 1 All ER 365.

¹⁶⁹ *Gillick supra*.

¹⁷⁰ Brazier & Cave (note 6 above; 400).

The court pointed out that the circular stipulated that doctors could provide contraceptives to girls under the age of 16 years in exceptional circumstances, those of which would only be unlawful if a physical act had been committed against her without her consent. However, the court held that a girl under the age of 16 is capable of consenting to medical treatment, including contraceptives, ‘if she is a normally intelligent girl who is reasonably capable of assessing the advantages and disadvantages of the proposed treatment and providing effective consent to such treatment.’¹⁷¹ The ability to consent will further depend on the child’s maturity and understanding.¹⁷² This would negate the need for additional inessential parental consent.¹⁷³ This principle is known as ‘Gillick competence.’

A Gillick competent child possesses sufficient maturity and intelligence to enable him or her to fully understand the treatment that has been proposed.¹⁷⁴ A child who displays Gillick competence is a child who has demonstrated a level of understanding that is sufficient and the heightened degree of competence and knowledge that enable him or her to make decisions for him or herself.¹⁷⁵ Such competence cannot be linked to age, but requires an assessment of the child’s development and maturity, and his or her ability to comprehend.¹⁷⁶ The Gillick competent child must display an understanding and appreciation of all associated short-term and long-term risks, as well as the emotional, social and psychological implications that result in consequence.¹⁷⁷ In order to ascertain this, questions are put to and discussions held with the child.¹⁷⁸

Gillick competence does not only encompass the right of a child to consent to treatment. It also allows a child to refuse medical treatment once they have satisfied the requirements of and have been considered to be ‘Gillick competent’.¹⁷⁹ Thus, this legal principle applies regardless of

¹⁷¹ *Gillick* supra note 168 at 374.

¹⁷² *Gillick* supra 373.

¹⁷³ *Gillick* supra 366.

¹⁷⁴ *Gillick* supra note 82 at 189.

¹⁷⁵ P Trowse ‘Refusal of Medical Treatment – A Child’s Prerogative?’ (2010) 10 (2) *QUTLJ* (2010) 206.

¹⁷⁶ *Ibid.*

¹⁷⁷ *Ibid.*

¹⁷⁸ *Ibid.*

¹⁷⁹ K McLean ‘Children and competence to consent: Gillick Guiding Medical Treatment in New Zealand’ (2000) 31 *VUWLR* 560.

whether children are consenting to or refusing treatment.¹⁸⁰ The only question that should be crucial to ask is whether or not the child is Gillick competent to make this decision of consent or refusal.¹⁸¹ One should not question the ability of a Gillick competent child to refuse medical treatment; it is equally testing to determine whether a child has the capacity to consent to treatment as it is to determine whether a child has the capacity to refuse the same treatment.¹⁸²

For years, the *Gillick* case meant that children had a right to say ‘no’ to treatment as much as they had a right to say ‘yes’.¹⁸³ The decision made by a Gillick competent child, who has the necessary maturity to refuse treatment, deserves respect and consideration,¹⁸⁴ which, quite obviously, implies that such decision cannot be disrespected by an overruling. The judge in this case had expressly stated that once a decision has been made by a Gillick competent child, the power of the parent of this child to consent or refuse terminates.¹⁸⁵ The parental right to determine whether or not the child undergoes medical treatment terminates upon the evidence of sufficient understanding and intelligence demonstrated by the child.¹⁸⁶ Parental decision-making authority ends when the child develops ‘sufficient intellectual and emotional maturity’ to make a decision.¹⁸⁷ This confirms that once a child has been declared to be sufficiently responsible to make an autonomous decision of refusing medical treatment, such decision should not be ‘open to veto’ by parents, health care professionals, or any other party.¹⁸⁸ This decision is one that regards the child’s own body and life and has been decided upon by an individual who is mature enough to take this responsibility for him or herself; therefore, this decision is one for him or her to make alone.¹⁸⁹ Hence, to attempt to constrain a competent person to undergo treatment to which they persistently object, or to merely raise an objection to the decision, would surely have negative consequences.¹⁹⁰ A Gillick competent child has the capacity, understanding and

¹⁸⁰ *Ibid.*

¹⁸¹ *Ibid.*

¹⁸² *Ibid.*

¹⁸³ Brazier & Cave (note 6 above; 404).

¹⁸⁴ Trowse (Note 175 above; 205).

¹⁸⁵ *Gillick* supra note 82 at 188-189.

¹⁸⁶ *Gillick* supra.

¹⁸⁷ *Department of Health & Community Services (NT) v JWB and SMB (Re Marion)* (1992) 66 ALJR (HCA) 340.

¹⁸⁸ McLean (note 179 above; 560).

¹⁸⁹ *Ibid.*

¹⁹⁰ Trowse (Note 175 above; 205).

maturity to weigh up the consequences of the decision that they have made.¹⁹¹ To disallow this competent decision on the basis of disapproving views from parents, health care professionals or other parties, is to violate and undermine the bodily integrity and autonomy of the 'Gillick competent' child, as discussed in a preceding chapter¹⁹²

It is noteworthy, as previously stated, that this principle offers no room for fixed age limits relying solely on the capacity of children to make decisions.¹⁹³ This correlates perfectly with the recommendations of a 'Mature Minor' approach being adopted. Therefore, it may be concluded that a child has the right to refuse medical treatment provided that they have the sufficient and necessary maturity to make this competent decision as well as to understand the nature, consequences, and the social, psychological and other implications of the decision. It is submitted that the South African legal system ought to consider implementing the principle of Gillick competence in addition to the 'Mature Minor' doctrine. Together, these two principles could form a test to assess the maturity of children to refuse medical treatment based on competence, as opposed to age.

3.6. Shortcomings of maturity as a test for competence and recommended methods of assessing maturity

The Mature Minor Doctrine and the principle of 'Gillick competence' appear to be rules that could easily be adopted by South African Law considering that the only prerequisite for a child to consent to or refuse medical treatment is the maturity to understand the nature and consequences of his or her medical condition as well as the treatment. The maturity level of a child to reach this understanding must be sufficient so as to enable the child to make competent decisions regarding whether or not to consent to or refuse medical treatment. However, determining the maturity of a child is particularly challenging.¹⁹⁴ The cases and legislation discussed above emphasize the importance of determining the level of maturity of children to

¹⁹¹ Ibid.

¹⁹² Ibid.

¹⁹³ *Gillick* supra note 82 above at 188.

¹⁹⁴ A Dhaj, 'Informed consent' (2008) 1(1) *SAJBL* 28.

make informed and autonomous decisions, yet do not specify the manner by which, nor the professional responsible for making this assessment.¹⁹⁵

3.6.1. Methods for determining maturity

Thus far, South African courts have not developed a systematic test by which to satisfy the legislative requirements to correctly assess the maturity and understanding of children.¹⁹⁶ There are no standards which guide the court in making a maturity assessment.¹⁹⁷ Hence, it is submitted that courts should clarify the legislative requirements that they enforce by enunciating specific guidelines to determine the maturity level of a child.¹⁹⁸ A consistent method for evaluating the ability of comprehension and the maturity level of a child would provide guidance, information and possibly answer all of the bemused questions by parents, healthcare professionals as well as the courts in situations where a child refuses medical treatment.¹⁹⁹ In similar terms, this would be the solution to all problems emanating from a child's refusal of medical treatment.

The simplest method of assessment would be a psychological one which would entail discussing with the child the nature, extent, risks and obligations of the proposed medical treatment as well as the effects and consequences of refusing such treatment.²⁰⁰ It is recommended that this must be done in the language preferred by the child considering the diversity of languages in South Africa.²⁰¹ Thereafter, the child may be asked to paraphrase the information that had been conveyed to him or her in order to understand, in the child's terms and in the child's preferred language, whether or not he or she truly understands the nature and consequences of the decision that they have reached.²⁰² It is submitted that in addition to this, a list of questions should be put

¹⁹⁵ Burden-Osmond (note 25 above; 213).

¹⁹⁶ KM Waters 'Judicial Consent to Abort: Assessing a Minor's Maturity' (1986) 54(1) *GWLR* 92.

¹⁹⁷ *Ibid*.

¹⁹⁸ *Ibid* at 109.

¹⁹⁹ Burden-Osmond (note 25 above; 215).

²⁰⁰ McQuoid Mason (note 11 above; 467).

²⁰¹ Section 6 of the Constitution of the Republic of South Africa, 1996, recognises the eleven official languages of South Africa and requires promotion and respect for these languages as well as other languages in use in South Africa that have not been declared as an 'official language' under section 6. These languages include Greek, German, Gujarati, Hindi, Hebrew, Sanskrit, Arabic, Portuguese, Tamil, Telegu and Urdu.

²⁰² McQuoid Mason (note 11 above; 467).

to the child that may be suitable for evaluating a child's ability to refuse medical treatment.²⁰³ Asking children whether they suffer from any symptoms or discomforts, as well as to describe the effects that the illness has had in their lives are questions that focus on their ability to understand the nature of their sickness, illness or disease.²⁰⁴ Questions such as, 'Do you think that you need treatment?' or 'Tell me the effects that the benefits of treatment will have on your life?' or simply, 'Why do you want to refuse treatment?' will assist in analysing the child's ability to understand the nature of the recommended treatment and why it is unwanted.²⁰⁵ Questions which probe the ability of children to appreciate the consequences of refusing treatment would be to ask them why they wish to refuse treatment, whether not receiving the treatment would benefit them²⁰⁶ and whether they understand the consequences of not receiving treatment. A personal conversation such as this would reveal a deeper understanding of the true feelings and capacities of the child to refuse treatment.

Courts have an obligation to render decisions that are logical, fair, judicious and reasonably formed and the dearth of tests to determine a child's maturity opens the floodgates for unfair arbitrary judgements.²⁰⁷ For that reason, a list of factors that would be relevant to the court's determination of maturity must be developed. A step in this direction is the case of *In re Moe*,²⁰⁸ where the court considered a list of factors to assist in establishing the maturity level of children. The court considered the child's tone of voice, expressions, and general demeanor; whether the child's responses were well informed and articulate; the degree to which the child evaluated and made decisions based on relevant information and the child's ability to understand the decision that they have made.²⁰⁹ Although the court in this case utilized these factors in connection with establishing the maturity of minor girls to consent to their own abortions, they are equally relevant to the assessment of the maturity of children to refuse medical treatment as they ultimately pertain to assessing the maturity of minors. The court in *Moe* considered pertinent factors to confirm a child's capability to make informed decisions, act independently and

²⁰³ Burden-Osmond (note 25 above; 215).

²⁰⁴ E Stein 'Mental Competency Determinations and the Law' (LLM thesis, York University, 1994).

²⁰⁵ *Ibid.*

²⁰⁶ *Ibid.*

²⁰⁷ Waters (note 196 above; 112-113).

²⁰⁸ (1981) 298 12 (Mass. App. Ct.) N.E.2d 1038 423.

²⁰⁹ Waters (note 196 above; 111).

demonstrate resolve and conviction in relation to their decisions.²¹⁰ It is recommended that such factors be adopted and further developed by the South African judicial system in order to offer guidance in the assessment of maturity as well as to perform a detailed analysis of the qualities of maturity, thereafter determining whether the child in question is able to display those qualities. Such recommendation would result in giving effect to the minor's right to refuse medical treatment.

3.6.2. The professional responsible for determining maturity

The most suitable professional accountable for determining a child's maturity and understanding remains uncertain. The accuracy of an ascertainment of maturity depends on the professional making the assessment; therefore, such professional must be qualified to specifically and correctly make maturity findings using distinctive expertise unique to them. Some cases have preferred the determinations made by judges, while others prefer that judges and courts merely be assisted by the expert opinion of witnesses in the healthcare profession.

Maturity assessments conducted by judges have been criticised for the formal and intimidating nature of judicial proceedings together with judges' limited, superficial and fleeting personal interaction with the child.²¹¹ Judges do not have the luxury of time nor is it in their mandate to specifically make maturity findings as judges are trained in judicial matters and it is judicial matters upon which their expertise lies.²¹² As learned as a judge may be in judicial matters, training in disciplines required for the fair and accurate assessment of a child's maturity level, such as medicine, psychology, interpersonal dynamics and sociology, are simply not possessed by judges.²¹³ It is submitted that judges are best assisted by medical professionals in making maturity appraisals.

²¹⁰ Ibid at 112.

²¹¹ Ibid at 113.

²¹² Ibid.

²¹³ Ibid.

The treating medical practitioner is usually the person who performs the assessment.²¹⁴ One would be of the opinion that the medical practitioner who is treating the minor would be the professional who has the most knowledge about the minor's medical condition as well as whether they understand the nature of it. The maturity level of the minor would be obvious to the treating medical practitioner as he or she is the individual who interacts with the minor mostly. This being the case, treating medical professionals do not hold the training or expertise that would reasonably prepare them to assess the maturity level of a child, rather, they are better equipped for providing a physiological assessment of the child.²¹⁵ Moreover, medical practitioners, like judges, do not have the extensive consultation time that is required to assess a child's competence and maturity.²¹⁶

Considering that the treating medical practitioners cannot correctly and precisely assess the maturity levels of children, proceeding one step further to a more focused and specialised field, the correct professionals whose expertise are required to make these assessments are individuals who have been trained in cognition and child development.²¹⁷ These professionals are able to assess a child's personality, maturity and capacity for understanding.²¹⁸ Child psychiatrists or individuals who specialise in behavioural medicine are specifically educated and skilled to assess children, their development and maturity.²¹⁹ Therefore, it is submitted that these trained individuals are better suited to assess the maturity levels of children, as opposed to judges or treating physicians.

3.7. Conclusion

Section 129 (2) of the Children's Act 38 of 2005 allows children to consent to their own medical treatment if they are over the age of 12 years and of sufficient maturity and have the mental capacity to understand the benefits, risks, social and other implications of the treatment. It has

²¹⁴ Burden-Osmond (note 25 above; 214). See *Ney v Canada (Attorney General)* (1993) 1301 (BC SC) where Hubbart, J. stated that it 'appears' that a doctor should draw maturity findings.

²¹⁵ Ibid. See also C Himonga & A Cooke 'A Child's Autonomy with Special Reference to Reproductive Medical Decision-making in South African law: Mere Illusion or Real Autonomy?' (2007) *IJCR* 354 – 355.

²¹⁶ Himonga & Cooke (note 215 above; 354).

²¹⁷ Ibid.

²¹⁸ Ibid.

²¹⁹ Ibid.

been submitted that the right to consent includes the right to refuse medical treatment if the child is sufficiently mature to understand the nature, risks and consequences of a refusal of medical treatment. A child who displays a sufficient level of maturity ought to have his or her decisions respected by others, irrespective of his or her age.²²⁰ This principle is known as the ‘Mature Minor’ doctrine. A principle that is similar to the ‘Mature Minor’ doctrine is that of ‘Gillick competence.’ It is submitted that these two principles as discussed above, should be adopted by the South African legal system. This submission is based on the fact that the competence of a child to refuse medical treatment is not linked to the age of the child. Whether or not a child is competent does not depend on the age of the child; it depends on the level of maturity possessed by the child. In light of the above discussion, the first recommendation made in this chapter is that Section 129 (2) of the Children’s Act be altered to include only a test of competence, rather than a test of age and competence. As mentioned above, in the event that the first recommendation cannot be implemented, the second recommendation is to change the wording of section 129 (2) to read, ‘who by age *or* maturity’.²²¹ This approach takes into consideration that the maturity levels of children differ. It accepts that children possess different levels of maturity at different ages, and that not all children over the age of 12 years are mature and not all children below the age of 12 years lack maturity.

Adopting a test for competence that requires an assessment of maturity may prove to be difficult considering that South African legislation requires the presence of ‘sufficient maturity’, but does not provide the means by which to determine this. It has been submitted in this chapter that one may determine the maturity of children by explaining the implications of a refusal of treatment to the child in simple language and in a language that the child is able to understand.²²² Thereafter, the child should be asked to paraphrase, in their preferred language, what has been explained in order to determine whether the child is making an informed refusal.

²²⁰ Will (note 109 above; 236).

²²¹ *Review of the Child Care Act Report* 141.

²²² Section 6 of the Constitution of the Republic of South Africa, 1996, recognises the diversity of languages amongst the citizens of South Africa and thus, recognises the eleven official languages of South Africa and requires promotion and respect for these languages as well as other languages in use in the Republic that have not been declared as an ‘official language’ under section 6. These languages include Greek, German, Gujarati, Hindi, Hebrew, Sanskrit, Arabic, Portuguese, Tamil, Telugu and Urdu.

Another method of determining maturity includes compiling a list of factors like those referred in the case of *In re Moe*. The court considered the child's tone of voice, expressions, and general demeanor; whether the child's responses were well informed and articulate; the degree to which the child evaluated and made decisions based on relevant information and the child's ability to understand the decision that they have made.²²³ It is recommended that the Children's Act be revisited in order to compile a list of these factors to determine the maturity level of children.

In addition to not stipulating a method by which to determine the competence of children, the Children's Act does not identify a professional who should make this determination. It has been recommended that child psychiatrists or individuals who specialise in behavioural medicine are specifically educated and skilled to assess children, their development and maturity. Individuals who are trained in cognition and child development also make accurate determinations of the maturity levels of children.

²²³ Waters (note 196 above; 111).

CHAPTER FOUR

The Constitutional Right to Bodily and Psychological Integrity

4.1. Introduction

The Constitution of the Republic of South Africa, 1996 is the fruit of a democratically-elected body that has drafted and adopted this revered document that has been described as ‘the most admirable constitution in the history of the world,’²²⁴ by Harvard Law Professor Cass Sunstein.

One of the three characteristics²²⁵ of our Constitution is that it is supreme, which demands that all laws or conduct that are inconsistent with it will be regarded as unconstitutional and invalid, as the Constitution is the highest law of South Africa and prevails over all other laws and conduct and binds all organs of state to the inclusion of Parliament and the President.²²⁶ The Constitution is largely recognized as the crowning achievement of the country’s breakthrough in the realization of human rights for all people.²²⁷ The rights afforded by the Constitution belong to all citizens of South Africa, irrespective of an individual’s class, colour, or age.²²⁸ This is a good indication that the rights provided for by the Constitution apply to all individuals equally and do not depend on the age of an individual. Children, as well as adults, possess constitutional rights and are protected by the Constitution.²²⁹ Accordingly, children are able to enjoy the same constitutional rights that adults enjoy. This confirms that constitutional rights do not suddenly mature, come into being and are capable of enjoyment only when one attains the age of majority; minors as well as adults possess constitutional rights on an equal plane.²³⁰ This is evidenced by

²²⁴ M S Kende *Comparative Constitutional Law: South African Cases and Materials in a Global Context* (2015).

²²⁵ The other two characteristics of our Constitution are that it is a normative and rights-based Constitution.

²²⁶ W Freedman *Understanding the Constitution of the Republic of South Africa* (2013) 2.

²²⁷ *Shabalala v Attorney General of the Transvaal* 1996 (1) SA 725 (CC) para 26.

²²⁸ *Shabalala supra* para 26.

²²⁹ Currie & De Waal op cit note 16 at 600.

²³⁰ *Planned Parenthood v Danforth* (1976) 428 US 52.

section 7 (1) of the Constitution which endorses the fact that both adults and children alike are bearers of the rights contained in the Constitution.²³¹ Section 7 (1) appears to have drawn inspiration from the UDHR which asserts that all human beings are born free and equal in dignity and rights,²³² strongly asserting that children possess and are entitled to exercise the very same rights that are afforded to adults.

The new constitutional dispensation identifies a vulnerable group in society, namely children.²³³ Since the labelling of children as a ‘vulnerable group’, section 28 had been included in the Constitution to provide them with exclusive protection and exclusive rights in areas where they were considered to be particularly vulnerable.²³⁴ These areas include, but are not limited to; family care, basic health care services, protection from neglect and degradation, and legal services.²³⁵ It is often an incorrect communal belief that the rights established by section 28 are the only rights that are afforded to children in the entire Constitution and that no other rights stipulated in the Constitution are for the enjoyment of children.²³⁶ While these rights certainly apply specifically to children, these are not the only rights that apply to them.²³⁷ Children are entitled to the application, benefit and protection of the other constitutional rights, similarly to adults.²³⁸ This is so considering that every child is afforded the same protection in the Bill of Rights as their adult counterpart.²³⁹ Although many of the rights found in section 28 of the Constitution mirror the rights found in other sections of the Bill of Rights, there are many rights that are not repeated in section 28; however, they still remain as important for children as the rights found in section 28.²⁴⁰ These rights include the rights to equality²⁴¹, dignity²⁴², bodily and

²³¹ Section 7 (1) of the Constitution states that, ‘This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the right of all people in our country and affirms the democratic values of human dignity, equality and freedom.’

²³² Article 1 of the Universal Declaration of Human Rights, 1948, GA Resolution 217A (III).

²³³ du Plessis, Govindjee & van der Walt op cit note 4 at 1.

²³⁴ Currie & De Waal (note 16 above; 603).

²³⁵ Section 28 of the Constitution of the Republic of South Africa.

²³⁶ du Plessis, Govindjee, van der Walt op cit note 4 at 2.

²³⁷ Ibid.

²³⁸ Ibid.

²³⁹ Currie & De Waal (Note 16 above; 600).

²⁴⁰ du Plessis, Govindjee, van der Walt op cit note 4 at 3.

²⁴¹ Section 9 of the Constitution.

²⁴² Section 10 of the Constitution.

psychological integrity²⁴³ and individual autonomy.²⁴⁴ The last two rights form the basis of the discussion in this chapter.

4.2. The constitutional right to bodily and psychological integrity and autonomy

As children are bearers of all rights afforded by the Constitution, they too are entitled to the right to bodily and psychological integrity found under the right to freedom and security of the person in terms of section 12 of the Constitution.²⁴⁵ The right to bodily and psychological integrity includes the right to make decisions concerning reproduction;²⁴⁶ to have security in and control over one's body;²⁴⁷ and the right not to be subjected to medical or scientific experiments without one's informed consent.²⁴⁸ The quintessence of this right is the right to self-determination, the right to autonomy, and the right to 'live the life that one has chosen.'²⁴⁹ These fundamental rights guarantee the sovereignty of individuals to make personal autonomous and independent choices that reflect their true desires.²⁵⁰

In medical law, these rights protect individuals from being subjected to any form of medical treatment that is against their wishes, and from any imposition of treatment that is a product of a third party's perception of being in the best interests of the patient concerned.²⁵¹ The right to bodily and psychological integrity is pivotal to the right to refuse medical treatment, hence, pivotal to the right to make end-of-life decisions.²⁵² Patients who wish to refuse medical treatment, including treatment that will hasten their death, are free to make this decision. In doing so, they are deciding what happens to their own bodies. These patients are merely

²⁴³ Section 12 (2) of the Constitution.

²⁴⁴ The right to individual autonomy is construed from the rights to privacy, freedom of religion, freedom of expression and freedom of association when read as a whole.

²⁴⁵ du Plessis, Govindjee, van der Walt op cit note 4 at 3.

²⁴⁶ Section 12 (2) (a) of the Constitution.

²⁴⁷ Section 12 (2) (b) of the Constitution.

²⁴⁸ Section 12 (2) (c) of the Constitution.

²⁴⁹ A Hughes *Human dignity and fundamental rights in South Africa and Ireland* (2014) 245.

²⁵⁰ Biggs (note 29 above; 95).

²⁵¹ Ibid.

²⁵² Ibid.

exercising their right to refuse medical treatment as permitted by the right to bodily and psychological integrity.

The rights to autonomy and self-determination provide that a patient commands and exercises the ultimate control over his or her own body and is free to make decisions regarding his or her health.²⁵³ To respect the requests of such patient is to recognise his or her rights to bodily and psychological integrity, dignity, and freedom that are inherent to a human being.²⁵⁴ These rights encompass autonomy of thought, will; and action.²⁵⁵ This enables patient's to engage in thought processes and think for themselves, make decisions on their terms and act in accordance with those wishes.²⁵⁶ It enables a person to understand the information that they have received, to undergo a process of deliberation and thereafter, effectively communicate a decision that is free from any external influence.²⁵⁷

While adults are presumed to be legally autonomous, children are automatically presumed to lack autonomous decision-making capabilities by virtue of being legally classified as a 'child,' that is, under the age of 18 years.²⁵⁸ Children are automatically presumed to hold diminished autonomy, requiring a third party to make personal decisions regarding their lives and well-being.²⁵⁹ However, it is submitted, that this automatic presumption, without an enquiry into the level of competence possessed by the child in question, contravenes the child's right to bodily and psychological integrity.²⁶⁰ As indicated above, children are entitled to exercise their rights to bodily and psychological integrity which automatically grants them the rights to autonomy and self-determination. It is submitted that in terms of these rights, children who are of sufficient maturity to make competent decisions as result of understanding information and being cognisant of the consequences resulting from their decisions, should be recognised as autonomous individuals who are entitled to exercise their rights to self-determination and bodily and

²⁵³ D Geisen 'From paternalism to self-determination and shared decision making' (1998) *Acta Juridica* 108. See A Dhali & DJ McQuoid-Mason *Bioethics, Human Rights and Health Law* (2011) 69-70.

²⁵⁴ *Ibid.*

²⁵⁵ R Gillon *Philosophical Medical Ethics* (1986).

²⁵⁶ Biggs (note 29 above; 95).

²⁵⁷ Hartman (note 30 above; 87).

²⁵⁸ *Ibid* at 88.

²⁵⁹ *Ibid.*

²⁶⁰ *Ibid* at 89-90.

psychological integrity. By giving effect to these rights, children are able to make decisions regarding their own bodies without parental influence. It is submitted that children should be authorized to refuse medical treatment and to enforce this decision in terms of the right to bodily and psychological integrity. This submission has been made for two reasons. The first reason is that children are equally entitled to the right to bodily and psychological and integrity. It is therefore submitted that they may exercise this right to effectively refuse medical treatment if they are sufficiently competent to exercise the autonomy that they have been automatically afforded by the right to bodily and psychological integrity. The second reason is that in order to give effect to the right to bodily and psychological integrity, it is obvious that children must be competent to make autonomous decisions and once competence has been confirmed, the competent refusal must be respected and enforced, even against parental wishes to the contrary.²⁶¹ It is submitted that the right to bodily and psychological integrity of a child should, clearly, depend on his or her capacity to exercise it. Children should not automatically be assumed to lack the competence to exercise this constitutional right. This is in line with the fact that adults are entitled to exercise their rights provided that they display competence to do so. In this way, adults and children would enjoy the right to bodily and psychological integrity to the same degree.

The basis of this submission is found in scientific research which demonstrates that adults do not exhibit understanding, reasoning and decision-making skills that are superior to the abilities of competent children.²⁶² In actuality, competent children are found to exemplify comprehension, reasoning and decisional capacities that are the equivalent of the capacities presented by adults.²⁶³ Studies illustrate that competent children are able to reach decisions with ‘intentionality and thoughtfulness’ that are no less than adults.²⁶⁴ It is illogical that children who display sufficient competence to refuse medical treatment be treated as passive recipients of medical healthcare when their ability to ‘navigate the system independently’²⁶⁵ is palpable and

²⁶¹ BJ Hill ‘Constituting children’s bodily integrity’ (2015) 64 (7) 1297.

²⁶² Hartman op cit note 30 at 88.

²⁶³ Ibid.

²⁶⁴ Ibid at 96.

²⁶⁵ Ibid at 98.

mature. Competent child are able to manage the process of decision-making independently, thus reaching competent decisions to refuse medical treatment.

Once a patient possesses the required level of autonomy, his or her right to bodily and psychological integrity is protected; thus, rendering nonconsensual intrusions of his or her body as an unlawful violation of his or her right to bodily and psychological integrity.²⁶⁶ These intrusions remain unlawful violations of a patient's right to bodily and psychological integrity even though they may constitute life-saving medical treatment.²⁶⁷ To interfere with a patient's body without justification in law or without informed consent, is an unlawful and wrongful defilement of his or her bodily and psychological integrity.²⁶⁸ Obtaining informed consent for the provision of medical care is essential as it promotes the right to self-determination by allowing patients to make rational autonomous decisions about their health and bodies, consequently, enhancing the patients' rights to bodily and psychological integrity.²⁶⁹ Therefore, any performance of medical treatment without the patient's informed consent will amount to a violation of their right to bodily and psychological integrity, and, possibly, a criminal charge for assault. Assault, in this regard, should not be viewed in a literal sense, but rather in the sense of a violation of a patient's bodily and psychological integrity²⁷⁰ considering that the basis of informed consent is the right to autonomy and self-determination.²⁷¹ It is submitted that the same principles must apply when an administration of medical treatment has been ordered against the refusal of a child, as his or her right to bodily and psychological integrity protects the child from unauthorized physical intrusions such as refused medical treatment. This should be the position notwithstanding parental demands.²⁷²

Compelling medical treatment against the wishes of children would violate the bodily and psychological rights that children enjoy. This had been addressed in the case of *Re L*²⁷³ where the court had ultimately concluded that the minor in question had 'freedom from unwanted

²⁶⁶ Biggs (note 29 above; 95).

²⁶⁷ Ibid at 96.

²⁶⁸ *Stoffberg v Elliott* (1923) CPD 148.

²⁶⁹ P Carstens & D Pearmain *Fundamental Principles of South African Medical Law* (2007) 882-883.

²⁷⁰ MN Slabbert *Medical Law in South Africa* (2011) 81.

²⁷¹ Carstens & Pearmain (note 269 above; 883).

²⁷² Hill op cit note 261 at 1295.

²⁷³ 632 A.2d (1993) (CSC) 59.

infringements of bodily integrity,' when her putative father requested a paternity test for which the minor would have had to undergo a blood test.²⁷⁴ The court in this case, therefore, had confirmed that a minor's bodily and psychological integrity rights are protected from intrusions of unwanted medical treatment. Further, this constitutionally guaranteed right safeguards minors against the commission of unsought life-saving medical treatment as illustrated in the case of *Re E.G.*,²⁷⁵ where a minor had refused blood transmissions for leukemia.²⁷⁶ The court upheld the child's refusal to be transfused and alluded that a competent child indeed has the right to refuse life-saving medical treatment as any commission of such rejected treatment would amount to a violation of the bodily and psychological integrity and privacy rights of the child.²⁷⁷ Therefore, it is submitted, as adults are comprehensively protected from any nonconsensual intrusions, in like manner, children should be accorded the same protection against coerced medical treatment by parents or other third parties.

The National Health Act²⁷⁸ prescribes the right to refuse medical treatment which extends to children inasmuch as it applies to adults.²⁷⁹ In terms of this act, competent children who are of sufficient maturity and possess sufficient mental capacity, are entitled to refuse life-saving medical treatment, without the consent of or assistance by a parent or any other third party.²⁸⁰ In light of this, once a competent child has exercised their right to bodily and psychological integrity by refusing life-saving, or other, medical treatment, such refusal must be respected. In turn, this would respect the constitutional bodily and psychological integrity rights of the child.

Complementing this right, are the provisions of the European Convention on Human Rights in terms of Article 8, which are inclusive of the rights to autonomy and self-determination, verifying that everyone has the right to respect for their private lives and that there should be no interference of the exercise of this right. The private life that this provision seeks to protect encompasses the right to bodily and psychological integrity.²⁸¹ A person's body is an intimate

²⁷⁴ *Re L supra* at 61.

²⁷⁵ (1989) N.E.2d 549 322. Discussed in detail in a subsequent chapter.

²⁷⁶ *Re E.G. supra*.

²⁷⁷ *Re E.G. supra* at 326.

²⁷⁸ 61 of 2003.

²⁷⁹ Section 6 (d) of the National Health Act 61 of 2003. See also McQuoid Mason (note 11 above; 467)

²⁸⁰ McQuoid Mason op cit note 11 at 467.

²⁸¹ 'Physical Integrity' available at <http://echr-online.info/physical-integrity/>.

and sacred aspect of this private life;²⁸² hence, even trifling infringements on a person's bodily integrity may be actionable as a violation of the constitutional right if this infringement is committed against the individual's will.²⁸³ The private life that is protected by this convention belongs to children, particularly in circumstances when children refuse medical treatment.²⁸⁴ It is submitted that when faced with a refusal of medical treatment, children may not be subjected to the treatment that they have refused as this would be done against their will, occasioning a violation of their private life and their constitutional right to bodily and psychological integrity as espoused and protected by Article 8 of the European Convention on Human Rights.

4.3. The application of the child's constitutional right to bodily and psychological integrity in terms of the Choice on Termination of Pregnancy Act 92 of 1996 and in terms of the Children's Act 38 of 2005

The constitutional right to make decisions regarding reproduction reveals that this is one of the most crucial aspects of exercising control over one's body, hence, the advent of The Choice Act.²⁸⁵ The Choice Act recognises the right of pregnant minors to determine their own fate as well as whether or not to undergo a termination of pregnancy;²⁸⁶ the choice is left wholly in the hands of the minor. Thus, in terms of reproductive rights, children have salient and expansive bodily and psychological integrity rights; however, outside of this ambit, protection of the child's right to bodily and psychological integrity is insufficiently governed.²⁸⁷ The Choice Act appears to fully endow and respect the right to bodily and psychological integrity of children in respect of the termination of pregnancy, but limits this constitutional right when a child refuses medical treatment.²⁸⁸ Section 129 (2) of the Children's Act grants consenting power to a child in respect of their own medical treatment, or the medical treatment of his or her child, provided that the child in question is above the age of 12 years and has the sufficient maturity and the mental

²⁸² *Y.F. v Turkey* (2003) HRCD 14 440.

²⁸³ *Storck v Germany* 61603/00 (2005) ECHR 406.

²⁸⁴ A Samantha & J Samantha *Medical Law* (2011) 243.

²⁸⁵ 92 of 1996. See Currie & De Waal (Note 16 above; 600).

²⁸⁶ *Christian Lawyers Association v Minister of Health* 2004 (10) BCLR (T) 1086.

²⁸⁷ Hill op cit note 261 at 1305.

²⁸⁸ du Plessis, Govindjee, van der Walt op cit note 4 at 17.

capacity to understand the benefits, risks, social and other implications of the proposed medical treatment. As previously discussed in the former chapter, the obvious corollary of the right to consent to medical treatment is the right to refuse medical treatment.²⁸⁹ In view of this, the right of the child to consent to medical treatment in terms of section 129 (2) carries with it the right of the child to refuse medical treatment. This confirms that children do have the right to refuse medical treatment. However, this right is limited by allowing parents, courts and the Minister to overrule a refusal of medical treatment by children,²⁹⁰ whereas, the decision to consent to or refuse consent to a termination of pregnancy rests solely with the minor in terms of the Choice Act. Section 5 (1) of the Choice Act recognises that the right to bodily and psychological integrity is a right that even a minor is extensively entitled to. It is a right that should be exercised alone, without interference by third parties, by stating that a termination of pregnancy may be performed *only* with the informed consent of the pregnant woman (which includes a minor of any age²⁹¹). This section is supported by section 5 (2) of the Choice Act which expressly does not require consent from third parties by declaring that ‘no consent other than that of the pregnant woman shall be required for the termination of pregnancy.’ These sections prove that the right to make decisions regarding one’s own body, the right to consent to or refuse consent to a termination of pregnancy, is a decision that only a competent minor is capable of reaching and parents, courts or the Minister do not possess rights to refute the right to bodily and psychological integrity of a minor. It was stated in the case of *Planned Parenthood v Danforth*,²⁹² that:

‘There is not and should not be any constitutional authority to give a third party, including the minor's parent, an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.’²⁹³

²⁸⁹ Lemmens (note 10 above; 479).

²⁹⁰ Section 129 (8) – (9) of the Children’s Act. Additionally, parents are entitled to approach the court for an order authorizing medical treatment against their objecting children.

²⁹¹ Section 1 (xi) of the Choice Act.

²⁹² (1976) 428 US.

²⁹³ *Danforth* supra note 230 at 74.

As a consequence, decision-making capabilities belong only to the minor. Substituted consent by third parties is only accepted when the minor pregnant girl is incompetent²⁹⁴ and this position is agreed with.

These provisions reveal the vast difference in the respect afforded to the right to bodily and psychological integrity of a child in terms of the Choice Act and in terms of the Children's Act. The Choice Act allows children to make autonomous decisions regarding their own bodies, thus sanctioning minor girls to consent to or refuse a termination of pregnancy without parental or legal intervention.²⁹⁵ The Children's Act, however, restricts the right of a child to refuse medical treatment by subjecting this right to parental or legal approval prior to the fulfillment of the child's wish to refuse treatment. It is submitted that similarly to the Choice Act, any restriction placed on the right of a child to refuse medical treatment should be limited to circumstances where the child is incompetent and does not present with sufficient maturity to understand the benefits, risks, consequences, social and other implications of the refusal. Restrictions should not be placed on a competent child who provides an informed refusal. Arguments in favour of the placement of this restriction in the Children's Act and not in the provisions of the Choice Act reason that pregnant minors are found to be in a unique position requiring a decision to be made, one yielding irreversible long-term consequences.²⁹⁶ Making a decision of this nature cannot be halted until the minor attains majority.²⁹⁷ Granted that this may be so, such an argument would not hold muster as minors who are facing any type of illness are also placed in the same 'unique' position as that of pregnant minors and thus, cannot be distinguished from them.²⁹⁸ The situation that ill minors are in is no different to that of pregnant minors. Ailing minors who refuse medical treatment likewise have a weighty decision to make, a decision which too, reflects their grave situation, need for immediate attention and engenders immense and irremediable consequences.²⁹⁹ Another argument supportive of the restriction in the Children's Act is that a refusal of medical treatment is potentially life-threatening; however, life is also at stake in cases

²⁹⁴ Section 5 (4) – (5) of the Choice Act.

²⁹⁵ Lemmens op cit note 10 at 492.

²⁹⁶ Hill op cit note 261 at 1314.

²⁹⁷ Ibid.

²⁹⁸ Ibid.

²⁹⁹ Ibid.

of termination of pregnancy, rendering this argument invalid.³⁰⁰ It is submitted that this restriction by the Children's Act is, therefore, unfounded and unnecessarily infringes the right to bodily and psychological integrity of a competent child.

The Choice Act is a well-developed embodiment of the complete and comprehensive recognition and respect purveyed to a minor's right to bodily and psychological integrity. It is submitted that since such extensive acknowledgement of this constitutional right is shown in the context of the minor's right to make reproductive health decisions, the same degree of respect can surely be shown in regard to the refusal of medical treatment by children. This submission is made considering that when a minor refuses to terminate her pregnancy; she is refusing the medical treatment associated with and necessary in the performance of a termination of pregnancy.³⁰¹ In essence, the minor is refusing medical treatment; treatment that she is at liberty to refuse in the reproductive health context, but is prohibited from refusing when medical procedures are considered. There is no clear rationale for limiting children's rights to bodily and psychological integrity in terms of the refusal of medical treatment, but extending it beyond borders where reproductive health is concerned.³⁰² It is submitted that the right to bodily and psychological integrity should be implemented and enjoyed by children in all contexts.³⁰³

4.4. Conclusion

The right to bodily and psychological integrity has been included in the Constitution of the Republic of South Africa to be equally exercised by adults and children. The right to bodily and psychological integrity encompasses the rights to autonomy and self-determination. This right allows children to make decisions regarding their bodies. In this regard, children are entitled to refuse medical treatment if they so wish. Further, this right protects children from unwanted intrusions. This right protects children from being forced to undergo medical treatment that they have refused.

³⁰⁰ Lemmens op cit note 10 at 492.

³⁰¹ du Plessis, Govindjee, van der Walt op cit note 4 at 18.

³⁰² Hill op cit note 261 at 1305.

³⁰³ Ibid at 1313.

It has been submitted that once a child is competent to exercise his or her right to bodily and psychological integrity, the child is competent to refuse medical treatment. Such a refusal of medical treatment must be respected and upheld. To compel a competent child, who is exercising his or her constitutional bodily and psychological integrity rights, to undergo treatment, will undoubtedly be an infringement of their rights.

CHAPTER FIVE

The Right of Children to Be ‘Treated’ in Accordance with Their Best Interests: What Is Really in the Best Interests of Children?

5.1. Introduction

South Africa holds the best interests of children in high esteem and the seriousness with which it takes such interests are reflected in various provisions.³⁰⁴ The Constitution makes it a vital right for children and a responsibility to be fulfilled that ‘a child’s best interests are of paramount importance in every matter concerning the child.’³⁰⁵ This provision has influenced the drafters of the Children’s Act³⁰⁶ to include the paramountcy of these interests in the Act. Therefore, section 9 of the Children’s Act was drafted to confirm that the best interests of the child shall be the primary consideration in all actions concerning the child undertaken by any person or authority.³⁰⁷ This section has been supplemented by section 7 of the Children’s Act which lists several factors that must be considered by relevance when determining what would be in the best interests of children.³⁰⁸ Of particular applicability to medical treatment are the consideration of the child’s age, maturity, and stage of development³⁰⁹ and the child’s emotional and physical security and his or her emotional, intellectual, cultural and social development, together with any disability or chronic illness from which the child may suffer.³¹⁰ Another factor that is of possible

³⁰⁴ A Moyo ‘Reconceptualising the “paramountcy principle”: Beyond the individualistic construction of the best interests of the child’ (2012) 12(1) *AHRLJ* 143.

³⁰⁵ Section 28 (2) of the Constitution of the Republic of South Africa, 1996.

³⁰⁶ 38 of 2005.

³⁰⁷ Section 9 of the Children’s Act 38 of 2005.

³⁰⁸ Section 7 of the Children’s Act 38 of 2005.

³⁰⁹ Section 7 (1) (g) (i) of the Children’s Act 38 of 2005.

³¹⁰ Section 7 (1) (h) – (j) of the Children’s Act 38 of 2005.

relevance to the consideration of what would be in the best interests of the child with regard to medical treatment, is the protection of children from any psychological or physical harm that may arise from subjecting the child to degradation or harmful behaviour.³¹¹

International and regional human rights conventions such as the United Nations Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) are comprehensive instruments which further confirm the importance of promoting the best interests of children. The CRC orders that:

‘In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.’³¹²

These provisions are reaffirmed by the ACRWC which stipulates that the standard of the best interest of the child is of paramount importance must be applied in all actions concerning the care, protection and well-being of a child.³¹³

The combination of these provisions guarantees that the best interests of the child will be given due consideration and will be the basis upon which all matters concerning the child will be decided. However, what is in the best interests of a child with regard to medical treatment remains unclear. Parents believe that it is in the best interests of their children to receive medical treatment;³¹⁴ while children who refuse medical treatment clearly hold the view that it is in their best interests not to undergo the medical treatment. It will be shown in this chapter that it is not always in the best interests of children to compel them to undergo medical treatment against their wishes. This is especially so when treatment is futile, offering little benefit to the child. It will be shown that compelling treatment to unwilling competent children infringes their constitutional rights to dignity and life. The right to dignity means that ‘patients have the right to have their

³¹¹ Section 7 (1) (l) (i) of the Children’s Act 38 of 2005.

³¹² Art 3(1) of the United Nations Convention on the Rights of the Child, GA Res 44/25, annex, 44 UN GAOR Supp (No 49) 167, UN Doc A/44/49 (1989) entered into force 2 September 1990.

³¹³ Art 4(1) African Charter on the Rights and Welfare of the Child, OAU Doc CAB/ LEG/24.9/49 (1990) entered into force 29 November 1999.

³¹⁴ P Muirhead ‘When parents and physicians disagree: What is the ethical pathway?’ (2004) 9 (2) *Paediatr. Child Health* 85.

dignity respected and protected' if the medical treatment will violate their dignity.³¹⁵ This may occur when invasive and futile medical treatment subjects the patient to indignity, especially in situations where the prognosis is hopeless and treatment continues against the patient's wishes.³¹⁶ The right to life, in a medical law context, suggests that a patient may end his or her life should he or she wish to do so.³¹⁷ It is submitted that competent children should be entitled to these rights. Children who are competent to refuse futile medical treatment should not be compelled to undergo treatment against their wishes. To do so, would violate their constitutional rights and cannot be said to be in their best interests.

5.2. Is it in the best interests of competent children to override their competent refusals of medical treatment?

Decisions which claim to be made in the best interests of children, such as overriding competent refusals of medical treatment by children, do not always reflect the wishes of competent children and usually reflect what parents want for their children and what they may deem best.³¹⁸ Parents have a genuine interest in preserving the life of their child to avoid the anguish of losing a child, or possibly, to abuse their authority.³¹⁹ For this reason, parents and courts will simply do the needful to 'keep the child alive' – at all costs, even if imposing unwanted medical treatment provides little benefit - as they believe that this would be in the best interests of the child when it would produce the opposite effect. Parents do not always act in the best interests of their child.³²⁰ In existence are powerful indications and incidents that attest to the fact that the failure of parents to consult their children in decision-making as well as to fulfill their wishes has proven harmful to well-being of their children.³²¹ The best interests of the child are best served by allowing the child to exercise his or her autonomy by making informed decisions,³²² even if these decisions include informed refusals of life-saving medical treatment. It is recommended that the competent

³¹⁵ McQuoid Mason (note 11 above; 467).

³¹⁶ *Ibid.*

³¹⁷ *Ibid.*

³¹⁸ Moyo *op cit* note 204 at 144.

³¹⁹ Lansdown *op cit* note 44 at 3.

³²⁰ *Ibid.*

³²¹ *Ibid.*

³²² Elliston (note 22 above; 42).

refusals of treatment, including life-saving treatment, made by competent children who possess sufficient maturity to make such decisions should be respected. Decisions made by minors who know what is best for them must be respected.³²³ Neither parents nor courts should prompt submission to medical treatment to which a competent child objects.³²⁴ It would be seen, however, that this practice has seldom been observed.

In a number of decided cases judges have illustrated their reluctance to regard the wishes of refusals of medical treatment by competent children as determinative. Satisfying the principles of Gillick competence or the Mature Minor Doctrine appear not to suffice, although a legal requirement,³²⁵ as a decision made by a child who does satisfy these principles may be overruled by the court or the child's parents.³²⁶ Courts or parents overrule competent refusals of medical treatment by children if they are of the opinion that the proposed medical treatment is in the best interests of the child.³²⁷ This being so, the lengthy assessment of competence becomes a meaningless exercise to the point where competence merely becomes one among many factors that the court considers when determining what would be in the best interests of the child.³²⁸ This is an incorrect application of the law as competence is the ground upon which children are judged in order to determine whether they are capable of making autonomous decisions concerning their health. Once competence has been established it should not be marginalized as if it holds no value for the sake of an objective notion held by parents and courts of what is in the best interests of the child. This has, unfortunately, been the common occurrence in several cases. One such case was that of *Re W (A Minor)*³²⁹ where the Court of Appeal had overridden child's decision to refuse medical treatment as the decision would result in the child's death.³³⁰ The court had correctly conceded that it cannot lightly and easily override the decisions made by a competent child; however, the court had followed this statement by incorrectly adding that it

³²³ Lemmens op cit note 10 at 493.

³²⁴ Elliston op cit note 22 at 36. This is the legally accepted practice in terms of The Children Act 1989 of the United Kingdom.

³²⁵ As inferred by section 129 (2) of the Children's Act which requires children to be of sufficient maturity and possess the mental capacity to understand the benefits, risks, social and other implications of the treatment.

³²⁶ Trowse (Note 175 above; 192).

³²⁷ Ibid.

³²⁸ Elliston op cit note 22 at 39.

³²⁹ (1992) 4 All ER 627.

³³⁰ Trowse (Note 175 above; 197).

could do so if it were in the best interests of the child.³³¹ An incorrect statement indeed as the court had further conceded that it is in the best interests of the child to fulfill his/her wishes and carry out his/her decisions.³³² It is submitted that a competent child knows what is in his or her best interests and if a refusal of medical treatment would be in those best interests then such refusal must be respected. The court in this case was well aware that the best interests of the child lie with respecting the decisions of the child.

The case of *Re M (Child: Refusal of Medical Treatment)*³³³ differs from the case of *Re W* in that the child concerned was found not to be competent;³³⁴ however, the court stated that outcome of the case would have been the same had the child been found to be competent as the court had expressed its power to overrule any decision made by a child heedless of whether the child was found to be competent or not.³³⁵ The court reasoned that the welfare of the child was the paramount consideration and if the decision made by the child negatively impacted this welfare, the court was obliged to intervene. The court placed emphasis on decisions which result in the death of the child and stated that ‘whatever the risk may be in overriding the child’s decision, it must be matched against the certainty of death.’³³⁶

In the case of *Re W*, the court made a finding of competence and nonetheless, had overruled the decision made by a competent child. In the case of *Re M*,³³⁷ the court had found that the child was not competent and accordingly, overruled the decision. It is submitted that the court in the case of *Re W* was wrong to overrule the decision of a competent child. Moreover, it is submitted, that the courts in both the cases of *Re M* and *Re W* were wrong to state that whether or not a child presents with competence would not affect the outcome of the case as the court will overrule any decision that it believes to be in the best interests of the child.³³⁸ In these cases the courts overturned the decisions for the same reason - the decisions made by the children to refuse medical treatment would ultimately result in the death of the children. This indicates that the

³³¹ *Ibid.*

³³² *Re W supra* at 643.

³³³ (2000) 52 BMLR 124.

³³⁴ *Re M supra.*

³³⁵ *Re M supra.*

³³⁶ *Re M supra* at 128.

³³⁷ (2000) 52 BMLR 124. See Trowse (Note 175 above; 199).

³³⁸ Trowse (note 175 above; 198).

court will overrule any decision which would increase a child's chances of dying, whether they are competent or not, as courts believe that any decision which hastens death cannot be said to be in the best interests of the child.³³⁹

The court in *Re W* had conceded that it cannot easily overrule the refusals of medical treatment made by competent children.³⁴⁰ Therefore, it is submitted, that courts should only overrule decisions by children who do not exhibit full and complete competence as it is in their best interests to disallow a decision that is made by children who do not have the competence to make such decision. It is submitted that this is the approach that must be adopted, as a child who is not competent to make a decision should not be permitted to do so. Such child must be protected from making incompetent decisions. It is further submitted that a decision made by a competent child should not be overridden under the reasoning that it is in the best interests of the child – a decision that has been overruled will only suffice as being in the best interests of the child if the child is incompetent to make an autonomous decision. In other words, overriding the decision of an incompetent child is appropriate; howbeit, it is inappropriate to override the judgements and decisions of a competent child as such child is no longer in need of protection.³⁴¹

5.3. The infringement of constitutional rights by overruling refusals of medical treatment by competent children

As preceding reasoning suggests, courts have conceded that its power to overrule the wishes of competent children must be used sparingly. However, courts have appeared to override the decisions of competent and incompetent children if those decisions, such as a refusal of medical treatment, result in serious long term risks or hasten death.³⁴² It is believed by courts and parents that refusals of medical treatment that result in long term risks and accelerated death are not in the best interests of children. It has been submitted that the court may well proceed to take such decisions except when faced with the decisions made by competent children. It is further submitted that it is in the best interests of incompetent children to override their decisions so as

³³⁹ Ibid at 199.

³⁴⁰ Ibid at 197.

³⁴¹ Ibid at 200 – 202.

³⁴² Ibid at 198.

to protect them from decisions that they do not have the necessary competence and maturity to make. However, competent children make competent decisions that will be in their best interests to carry out. Decisions made by competent children must be respected and upheld irrespective of whether death is imminent, as is the practice where adults are concerned.

More often than not, courts do not intervene when faced with the long term health risks or the accelerated death that is consequential of refusals of medical treatment by adults.³⁴³ Once a person attains the age of majority and legally enjoys adult status, competence is presumed and if not rebutted, decisions made by such individuals must be respected by family and healthcare professionals. These decisions will be upheld by the courts without question (provided that threats to public health or pregnancy have been ruled out³⁴⁴) irrespective of the detrimental or fatal consequences which follow a refusal of medical treatment.³⁴⁵ This has been clearly endorsed in *Re T (adult: refusal of medical treatment)*,³⁴⁶ where Lord Donaldson had recognised that every adult has the *prima facie* right and capacity to decide whether to accept or refuse medical treatment, regardless of whether the latter may risk permanent injury to health or result in premature death.³⁴⁷ He further acknowledged that issues surrounding whether or not the reasons for the refusal were rational, irrational, unknown or possibly non-existent were redundant.³⁴⁸ It is for this reason that section 129 (8) which confers power on the Minister to consent to the medical treatment that has been unreasonably refused by children cannot be said to be a fair practice. Competent adults are permitted to refuse medical treatment even if the reasons for such objection are unreasonable and illogical and arouse fatal consequences. As a result, competent children should be afforded the same right. Support for this right has been found in jurisdictions even beyond our own, such as Canada, per Robins J.A. in the renowned case of *Malette v Shulman*.³⁴⁹ The judge in this case had confirmed that the right to self-determination encompasses the right to refuse medical treatment if one so wishes as a competent adult has the right to refuse specific or all treatment even if this refusal would guide them down a

³⁴³ Elliston (note 22 above; 40).

³⁴⁴ *Ibid* at 41.

³⁴⁵ *Ibid*.

³⁴⁶ (1992) 4 All ER 649.

³⁴⁷ *Re T supra*.

³⁴⁸ *Re T supra*.

³⁴⁹ (1990) 67 DLR 328.

path filled with risks as serious as death, and ‘may appear mistaken in the eyes of the medical profession or of the community.’³⁵⁰ This stance settles the argument that the best interests of the patient are determined on the basis of ensuring that the autonomy of the patient is respected in terms of fulfilling their wishes regarding medical treatment, albeit the lack thereof.³⁵¹

The best interests of the patient are not measured with the purpose of preserving the health and the life of the patient, at all costs, irrespective of the quality of such life.³⁵² This position is supported by our law in terms of section 6 (d) of the National Health Act,³⁵³ which permits competent individuals to refuse health services. The application of this section does not extend to competent adults alone, but to competent children as well in parallel.³⁵⁴ A child will be able to refuse medical treatment and have such refusal respected provided that the implications, risks and obligations of the refusal of medical treatment have been explained to the child and in return, have been understood and accepted by them.³⁵⁵ In addition, the child must be sufficiently mature and competent to understand the nature and effect of the refusal.³⁵⁶ The violation of this right arises when this refusal of medical treatment by a child may be overridden if parents and courts hold the view that it is in the best interests of the child to do so as the lack of treatment that the child demands will lead to the death of the child.³⁵⁷ It is irrational and arbitrary that the competent refusals of adults are respected and upheld, but the competent refusals of children are not. After all, they both have one quality in common and that is competence which ultimately distinguishes between individuals who may make autonomous decisions and those who may not due to their lack of competence. It is submitted that refusals of medical treatment by competent children must be respected and espoused, irrespective of imminent death. It is illogical and unfair to override a competent refusal of medical treatment by a competent child who chooses a peaceful death over living with a harrowing ailment. It cannot be said to be in the best interests of the child to overrule his or her refusal thus, forcing the child to endure the pain and agony of the ailment and moreover, endure further torment by undergoing unsolicited treatment. The pain,

³⁵⁰ *Malette supra.*

³⁵¹ Elliston (note 22 above; 41).

³⁵² *Ibid.*

³⁵³ 61 of 2003.

³⁵⁴ Boezaart (note 75 above; 216).

³⁵⁵ McQuoid Mason *op cit* note 13 at 531.

³⁵⁶ *Ibid.*

³⁵⁷ *Ibid.*

agony and torment that an adult is legally entitled to refuse to endure throughout his or her life whereas a competent child is compelled to succumb to suffering of the like, as the view that ‘treatment will always be in the best interests of the child’ is absurdly held.³⁵⁸ Life is not always better than death.³⁵⁹ Treatment does not always provide relief, nor is it always pleasant. There are many instances where treatment does more harm than good, or it may appear to bring short term relief without any prospect for long term benefits and is highly invasive, painful and results in negative long-term effects.³⁶⁰ In most cases the medical treatment that has been refused has been extensive treatment that offers no reasonable hope of recovery or improvement and do not provide the child with any benefit.³⁶¹ Such futile medical treatment provides little or no positive effect on or benefit to the child; on the contrary, it deteriorates the quality of life of the child. It is submitted that it is not in the best interests of the child to subject the child to medical treatment that compromises his or her dignity and provides no or little benefit for a short period of time while reducing the child’s quality of life for the rest of his or her life. It cannot be in the child’s best interests to compel medical treatment purely to ensure the child’s survival where such survival proves to be meaningless.

A meaningless survival and a meaningless life have been addressed in the recent case of *Stransham-Ford v Minister of Justice And Correctional Services and Others*.³⁶² Granting that this case had addressed the legality of active voluntary euthanasia in the form of doctor-assisted suicide, matters of which are not for discussion presently; nevertheless, the principles regarding the quality of life are relevant to the issue at hand. The court held that in determining the quality of life of a patient, the court must be influenced by the underlying values of the Constitution.³⁶³

³⁵⁸ Elliston (note 22 above; 44).

³⁵⁹ Ibid at 41.

³⁶⁰ Hill (note 261 above; 1312)

³⁶¹ Definition of ‘futile medical treatment’ provided by the World Medical Association.

³⁶² 30 April 2015. Case no. 27401/15 (NGHC) (unreported). The applicant in this case, Mr. Stransham-Ford, suffered from terminal stage 4 cancer with only a few weeks left to live. Mr. Stransham-Ford had suffered immense pain accompanied by nausea, stomach cramps, constipation, disorientation, vomiting, weight loss, increased weakness and frailty, anxiety, high blood pressure and loss of appetite. He was confined to his bed and subjected to injections, drips as well as morphine and other painkillers without which he was unable to sleep. As a result of such severe affliction, Mr. Stransham-Ford had made an urgent application to the court stating that a medical practitioner who administers or provides a lethal agent to him to end his life or allow him to end his life will not be acting unlawfully and thus, will be free from any civil, criminal or disciplinary liability. See *Stransham-Ford supra* paragraphs 3, 4, 7.1, 7.2 – 7.5 and 23.

³⁶³ *Stransham-Ford supra* para 23.

The most important of these values being the right to dignity which is linked to the right to life, and the right to life cannot insist that a mentally competent individual 'is obliged to live, no matter what the quality of his life is.'³⁶⁴ It is, therefore, submitted that courts will not be in favour of subjecting patients to medical treatment that they object to, merely to preserve their life - a life without dignity. Even more so, courts, which strive to adhere to the paramountcy of acting in the best interest of the child,³⁶⁵ surely cannot enforce an administration of medical treatment against an objecting child who wishes to die with dignity, rather than living a life without it. Such coercion will not be in the best interests of the child considering that the right to life and the right to dignity are so inextricably linked that the constitutional right to life cannot be enjoyed if an individual is compelled to live a life without dignity.³⁶⁶ A competent child cannot be obligated to live and be burdened with a life without dignity; a life that an adult will not be expected to live.³⁶⁷ Hence, it is submitted, that the right to life includes the right to die when life can no longer be carried out in a dignified manner. This is inferred by section 11 (3) of the Children's Act which bestows a right on children suffering with disabilities or chronic illnesses not to be subjected to medical, social, cultural or religious practices that will prove to be detrimental to their health, well-being and dignity. Children who fall victim to these malaises, and competent children, of whom are seemingly not mentioned in this section, who suffer from any illness, sickness or disease that they express competent refusals of medical treatment for

³⁶⁴ *Stransham-Ford supra*. The court held that the prohibition of active euthanasia in terms of the common law of South Africa (in so far as the common law crimes of murder and culpable homicide prohibit active euthanasia. See *Stransham-Ford supra* para 26) 'unjustifiably limit the Applicant's constitutional rights to human dignity and freedom of bodily and psychological integrity, and to that extent, are 'overbroad' and 'unconstitutional'. It is noteworthy that apart from the situation that arose in the *Stransham-Ford* case which dealt with active voluntary euthanasia, the common law crimes of murder and culpable homicide were not affected by this judgment. See *McQuoid-Mason* (note 13 above; 527) and *Stransham-Ford supra* para 26.

³⁶⁵ As conferred by section 28 (2) of the Constitution and section 7 of the Children's Act 38 of 2005.

³⁶⁶ O'Reagan J had stated in the case of *S v Makwanyane* 1995 (3) SA 391 (CC) that the right to life entails a life that is worth living:

'The right to life is, in one sense, antecedent to all other rights in the Constitution. Without life in the sense of existence, it would not be possible to exercise rights or to be the bearer of them. But, the right to life was included in the Constitution not simply to enshrine the right to existence. It is not life as mere organic matter that the Constitution cherishes, but the right to human life: the right to share in the experience of humanity. This concept of human life is at center of our constitutional values. The Constitution seeks to establish a society where the individual value of each member of the community is recognised and treasured. The right to life is central to such a society. The right to life, thus understood, incorporates the right to dignity. The rights to dignity and to life are intertwined. The right to life is more than mere existence; it is a right to be treated as a human being with dignity - without dignity, human life is substantially diminished. Without life, there cannot be dignity.'

³⁶⁷ *Elliston* (note 22 above; 44).

should not be subjected to medical, social, cultural or religious practices that will be detrimental to their health, well-being and dignity. Competent refusals of medical treatment by children regarding any type of disability or illness should be respected and fulfilled, especially once such treatment compromises the dignity of the child. To compel treatment against the child's wishes would infringe their constitutional rights to life, dignity as well as bodily and psychological integrity.³⁶⁸

It is regarded as cruel and inhuman, behaviour that all individuals are constitutionally protected against,³⁶⁹ to subject a child to a life filled with pain and suffering, a life that is 'demonstrably going to be so awful' that such child must be condemned to die in dignity.³⁷⁰ Children who decide to forego life-saving treatment and live out the rest of their lives with dignity should be allowed to die in dignity as this is the right that is enjoyed not only by adults - it is the fundamental human right of all to be able to die with dignity which our courts are obliged, in terms of Sections 1 (a), 7 (2) and 8 (3) (a) of the Constitution,³⁷¹ to 'advance, respect, protect, promote and fulfil.'³⁷² Consequently, to deny children the right to die in dignity would be in direct conflict with these stipulated rights as our Constitution has been founded on dignity, the advancement of human rights and freedoms as well as the achievement of equality.³⁷³ Depriving competent children of the right to die in dignity, a right that competent adults are freely entitled to, by no means protects dignity or achieves the equality that our Constitution strives to ensure. It is illogical to tell a severely ill individual who is capable of competently refusing medical treatment that he or she must endure the indignity of the excruciating pain and suffering, and is

³⁶⁸ McQuoid Mason (note 11 above; 467).

³⁶⁹ Section 12 (1) (e) of the Constitution protects individuals against being treated or punished in ways that are cruel, inhuman or degrading.

³⁷⁰ *Re B (a minor) (wardship: medical treatment)* (1981) 1 WLR 1421.

³⁷¹ Section 1 (a) of the Constitution stipulates that the Republic of South Africa is one, sovereign, democratic state founded on human dignity, the achievement of equality and the advancement of human rights and freedoms. Section 7 (2) of the Constitution confers responsibility on the state to respect, protect, promote, and fulfill the rights in the Bill of Rights. Section 8 (3) (a) states that a court, when applying a provision of the Bill Of Rights in terms of subsection (2) – subsection (2) indicates that a provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right – must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right, in order to give effect to that right.

³⁷² *Stransham-Ford* supra note 336 at para 14.

³⁷³ Section 1 (a) of the Constitution of the Republic of South Africa, 1996.

not permitted to refuse treatment to die in a dignified manner.³⁷⁴ It is even more absurd to expect a child to suffer this fate. It is submitted that holding these expectations of a child and coercing a meeting of such expectations would not be in the best interests of the child.

Undermining the right of a child to refuse treatment in order to embrace death with dignity, in addition to compelling an administration of the unwelcomed treatment, does not only infringe constitutional rights, but directly violates statutory law in terms of section 7 (1) (i) and (ii) of the Children's Act. These sections ensure that children are protected, when determining what would be in their best interests, from any psychological or physical harm that may result from subjecting them to degradation or harmful behaviour. Subjecting an unwilling competent child to medical treatment exposes such child to physical harm that is accompanied by forcing the child to endure degrading medical treatment which encroaches upon his or her right to dignity as well as the right not to be subjected to degradation or harmful behaviour, as inferred by section 7 (1) (i) and (ii) of the Children's Act. Furthermore, forcing a child to undergo medical treatment causes the emotional trauma that the Children's Act seeks to protect - this impinges the right of a child to be protected from damaging psychological harm arising from coerced medical treatment. In the case of *Re LDK*,³⁷⁵ the court found that the emotional distress of receiving an unwanted blood transfusion (the same applies to unwanted treatment) would have a negative effect on treatment as well as on the child and that the purpose of healthcare is to ensure the well-being of all patients, in both emotional and physical respects, and compelling medical treatment cannot achieve this end.³⁷⁶ For these reasons, denigrating a child's competent refusal of medical treatment as they prefer to die with dignity will not suffice as a decision taken in the best interests of the child.

In consequence, our law must be developed, as required by our Constitution, to protect the right of children to die with dignity in order to give effect to and respect this right.³⁷⁷ At present, this

³⁷⁴ *Stranham-Ford* supra note 336 at para 14.

³⁷⁵ This is a Canadian case that is untraceable. This case, however, has been cited, albeit without a reference, in the case of *Re E (a minor) (wardship: medical treatment)* (1993) 1 FLR 386. See Elliston op cit note 306 at 43.

³⁷⁶ Elliston op cit note 22 at 43.

³⁷⁷ This must be done in terms of section 8 (3) (a) of the Constitution which states that a court, when applying a provision of the Bill Of Rights in terms of subsection (2) – subsection (2) indicates that a provision of the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature

is currently in progress as courts are expressing reluctance to overrule informed refusals made by competent children as the constitutional rights of the latter are gradually attaining recognition and respect.³⁷⁸

5.4. Conclusion

The best interests of children are a paramount consideration in all matters affecting them. This has been confirmed by the Constitution and the Children's Act 38 of 2005, as well as international and regional human rights conventions. As indicated in the discussion above, parents and children have different perceptions of what would be in the best interests of the child concerned. It has been submitted in this chapter that compelling competent children to undergo medical treatment against their wishes is not always in their best interests. This is especially so when treatment is provides little benefit for the child. It has been submitted that compelling medical treatment against the wishes of the child would infringe upon their constitutional rights to dignity and life. The right to dignity allows a child to refuse medical treatment that would compromise their dignity. This occurs when the medical treatment causes more harm than it provides benefit. The right to life allows a child to end their lives if they wish. Children should be allowed to exercise these constitutional rights when they refuse medical treatment.

of the right and the nature of any duty imposed by the right – must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right, in order to give effect to that right.

³⁷⁸ McQuoid Mason op cit note 13 at 531.

CHAPTER SIX

The Right of Children to Refuse Medical Treatment Based on Religious Beliefs

Medicine is a practice and a spiritual path. Remembering this deep meaning is what keeps us from burning out, and it is what keeps us alive. We must always remember that we serve life through Medicine, not because it is broken, but because it is Holy.

- Rachel Naomi Remen

6.1. Introduction

The above quotation made by MD, Founder and Director of The Institute for the Study of Health and Illness, encapsulates the importance of religion and faith in the sphere of Medical Law and emphasizes that one sphere cannot be successful without the other – one cannot experience healing without faith in the healthcare system, neither can one practice Medicine without the practice of faith.

Religious beliefs generally lie at the heart of the family.³⁷⁹ These strong beliefs are passed on from generation to generation and accumulate strength in the hearts and minds of believers to such an extent that they base medical decisions on these beliefs. It is for this reason that numerous religious groups oppose the idea of conventional medical treatment³⁸⁰ and refuse the assistance of doctors, the use of drugs as well as the intervention of surgery as they prefer to rely on God, prayer and faith for healing.³⁸¹

³⁷⁹ KL Diaz 'Refusal of Medical Treatment Based on Religious Beliefs: Jehovah's Witness Parents' (2007) 16 J. *Contemp. Legal Issues* 85.

³⁸⁰ JL Hartsell 'Mother May I... Live? Parental Refusal of Life-Sustaining Medical Treatment for Children Based on Religious Objections' (1999) 66 *Tenn. L. Rev.* 503.

³⁸¹ AD Lederman 'Understanding Faith: When Religious Parents Decline Conventional Medical Treatment for Their Children' (1995) 45 *CASE W. RES. L. REV.* 891.

The most widely recognized religious denomination is the First Church of Christ Scientists, also known as ‘Christian Science’, which was founded in 1879 by Mary Baker Eddy in New England.³⁸² Christian Scientists do not believe in the reality of sicknesses, diseases or disorders and rather hold the belief that ailments, illnesses, and maladies are manifestations of the mind that are only capable of healing by praying and drawing closer to God.³⁸³ Christian Science healers are commonly known as ‘practitioners’ and the manner in which they perform their duties are by the practice of pure, heartfelt and meticulous prayer which brings about a profound understanding of a person’s actual spiritual being as a child of God.³⁸⁴ This understanding is essential in dissolving the mental state of the ill person from which all sicknesses and diseases stem.³⁸⁵ Other religious sects who spurn modern day medical treatment and promote healing through prayer and faith include The Church of God of the Union Assembly, Inc., General Assembly and Church of the First Born, Faith Assembly Church, Faith Tabernacle Church, No Name Fellowship and Jehovah’s Witnesses.³⁸⁶ Of these denominations, Jehovah’s Witnesses appear to be the most prevalent form in South Africa.

Jehovah’s Witnesses, though their population is fairly small, have often created difficulties for our courts as a result of their unique beliefs.³⁸⁷ They believe that they will lose their eligibility to enter ‘paradise’ if they accept blood transfusions³⁸⁸ as Biblical verses³⁸⁹ forbid believers from ‘eating blood’ which Jehovah’s Witnesses believe to be the equivalent of a blood transfusion. Unlike other religious groups who reject all methods and forms of conventional medical treatment, believers of the Jehovah’s Witness faith largely accept most forms of conventional medical treatment. However, they shun the use of blood transfusions and even avoid undergoing medical procedures and operations which may increase the likelihood of requiring blood

³⁸² EA Lingle ‘Treating Children by Faith: Colliding Constitutional Issues’ (1996) 17 J. *Legal Med* 306. Ms. Eddy claims that she was healed suddenly through prayer and the reading of the New Testament after sustaining injuries after a severe fall.

³⁸³ *Ibid.*

³⁸⁴ NA Talbot ‘The Position of the Christian Science Church’ (1983) *NEW ENG. J. MED.* 1642.

³⁸⁵ *Ibid.*

³⁸⁶ Hartsell (note 380 above; 505).

³⁸⁷ Diaz (note 379 above; 89).

³⁸⁸ *ibid* 85.

³⁸⁹ Believers rely on the Biblical passage of *Leviticus* 17:10 (KJV) which states, ‘And whatsoever man...eateth any manner of blood; I will even set my face against that soul that eateth blood, and will cut him off from among his people.’

transfusions for its success.³⁹⁰ Members of the Jehovah's Witness faith even reject the recirculation of their own blood once it has been removed from their bodies as it is no longer considered pure.³⁹¹

Jehovah's Witnesses are well aware of the consequences of their decisions to refuse blood transfusions and accept the fact that the failure to accept a blood transfusion may result in their death.³⁹² It is important to note that competent adult believers who reject medical treatment including blood transfusions, have a constitutionally protected right to do so.³⁹³ This right is protected by the Constitution of the Republic of South Africa³⁹⁴ in terms of section 15 (1) which states that everyone has the right to freedom of conscience, religion, thought, belief and opinion. This section allows any competent adult to refuse any form of medical treatment even if death is likely to ensue. The right of a competent adult to refuse medical treatment is also guaranteed by the National Health Act 61 of 2003 which confers an obligation on a health care provider to inform the health care user of their right to refuse health services and explain the risks, implications and obligations of such refusal.³⁹⁵ This right is further supported by the right to privacy and self-determination,³⁹⁶ which allows one to decide their own fate and make decisions that are not obstructed by any external influences. It allows a person to carry their decision through without the fear of interference. The right to self-determination is drawn from the constitutionally affirmed right to security in and control over one's body³⁹⁷ which permits the bearers of this right the freedom to decide what happens to their own bodies. Accordingly, when an adult makes the decision to refuse medical intervention that could even be life-saving, having full capacity to do so, the courts accept this decision without intervening.

The position is different when minor children are involved. It is evident from the above that religious credence and pressure received from parents who are deep into their faith, often prevent

³⁹⁰ Lederman (note 381 above; 891).

³⁹¹ Hartsell (note 380 above; 506).

³⁹² Ibid.

³⁹³ Diaz (note 379 above; 86).

³⁹⁴ 1996.

³⁹⁵ Section 6 (d) of the National Health Act 61 of 2003.

³⁹⁶ *Cf Washington v Glucksberg* (1997) 321 US 702, 724.

³⁹⁷ Section 12 (2) (b) of the Constitution of the Republic of South Africa, 1996.

a child from consenting to medical treatment and thus, is coerced into refusing what could sometimes be regarded as life-saving medical treatment.

6.2. Parental refusal of medical treatment for their children based on religious grounds

It is not uncommon for parents to refuse medical treatment for their minor children solely because of their religious objections or to coerce their children into refusing medical treatment due to religious beliefs, even though these refusals may result in the death of the child.³⁹⁸ A medical practitioner who wished to overrule these decisions by parents were welcome to approach the High Court for an order of the same and the High Court would act as the upper guardian of all minor children.³⁹⁹ This was a common occurrence prior to the provisions of the Children's Act and an influential judgement - doctors are no longer required to obtain a court order to overturn parental refusals as refusals of medical treatment by parents that are based on religious grounds alone have now been deemed as unconstitutional and therefore, unlawful.⁴⁰⁰

This influential judgement made by the High Court in *Hay v B*⁴⁰¹ was reached after Dr Hay, the paediatrician attending to the infant, applied to the court as matter of urgency for an order authorizing her to administer a life-saving blood transfusion to an infant despite objections by the parents that the blood transfusion was contrary to their religious beliefs and that they had concerns relating to the risk of infection that may result from the transfusion.⁴⁰² Dr Hay testified that there was no guarantee that the infant would survive if the blood transfusion was administered; however, she could in 'all probability'⁴⁰³ state that if it was not, the infant would definitely not survive.⁴⁰⁴ She further testified about the unlikelihood of the blood being

³⁹⁸ Hartsell (note 380 above; 501).

³⁹⁹ DJ McQuoid Mason 'Parental refusal of blood transfusions for minor children solely on religious grounds – the doctor's dilemma resolved.' (2005) 95 (1) *SAMJ* 29.

⁴⁰⁰ *Hay v B* 2003 (3) SA 492 (W).

⁴⁰¹ *Hay supra* note 34 at 493.

⁴⁰² *Hay supra* note 34 at 494.

⁴⁰³ *Hay supra*.

⁴⁰⁴ *Hay supra*.

contaminated to spread infection due to the blood screening procedures that are conducted prior to the administration of a blood transfusion.⁴⁰⁵ The High Court held that while the parents' religious beliefs should not be ignored and rather respected and considered, '...the evidence established that their beliefs negated the essential content of the infant's right to life.'⁴⁰⁶ This means that the parents' religious contentions were neither reasonable nor justifiable and could not override the infant's right to life as this right is a basic constitutional value that was inviolable.⁴⁰⁷ The High Court granted an order authorizing Dr Hay to administer the blood transfusion to the infant indicating that the best interests of the child are of paramount importance according to our Constitution that further, the interests of the infant outweighed the parents' religious disputations.⁴⁰⁸ The advent of this case resulted in the unconstitutionality of parental refusal of medical treatment solely on religious grounds; therefore, these reasons for refusal by parents will not suffice.

Courts further respond to the dilemma of conflicting rights of adamant parents and their pressured children by referring to the case of *Prince v Massachusetts*⁴⁰⁹ where the court held that the right to practice religion freely does not include liberty to expose a child to communicable disease, ill health or death.⁴¹⁰ The court quoted:

'Parents may be free to become martyrs themselves, but it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.'⁴¹¹

Religious dogmas compel parents to refuse medical treatment which, in turn, places encumbering pressure on their children to hold the same view and refuse medical treatment for themselves.⁴¹² The court in *Prince* concludes that parents cannot refuse medical treatment for their children, or

⁴⁰⁵ *Hay supra*. In her efforts to appease the reluctant parents, Dr Hay even expressed her willingness to withdraw blood from the parents provided that they were a match for the infant to receive - a suggestion which was also rejected by the parents.

⁴⁰⁶ *Hay supra* note 34 at 495.

⁴⁰⁷ *Hay supra*.

⁴⁰⁸ *Hay supra*.

⁴⁰⁹ (1944) 321 US 158.

⁴¹⁰ *Hay supra*.

⁴¹¹ *Hay supra*.

⁴¹² C Bridge 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 (4) *MLR* 587.

influence them to do so, solely on the basis that it is not in accordance with their religious tenets. This decision is not theirs to make.

Shortly after the judgement of the case of *Hay*, the Children's Act 38 of 2005 provided a clear direction, although poorly abided by even in the present day, in which to proceed. It now protects children from these parental decisions and intimidation to refuse medical treatment on religious grounds by requiring parents to provide a medically accepted alternative to the medical treatment or surgical operation that they are refusing for their children.⁴¹³ In the absence of this alternative,⁴¹⁴ and in the presence of a refusal, courts are virtually unanimous in authorizing the transmission of the blood transfusion despite the religious objections by the parents.⁴¹⁵ Courts can only order the commission of medical treatment if a dispute reaches the court. Many cases are not presented to court for resolution and are left unsettled usually at the expense of the child. If the situation does not reach the court timeously to save the life of the child, the parents may face criminal charges of child maltreatment or abuse, culpable homicide or even murder.⁴¹⁶ Although some states have a 'spiritual treatment' clause which exonerates parents from prosecution or provides a defence that they were exercising their religious beliefs in good faith,⁴¹⁷ South Africa does not grant the same leniency. The view maintained is supported in this dissertation.

As seen from the above, courts are not impressed by parents who refuse medical treatment for their children or burden them with the pressures of doing so themselves and will not tolerate such decisions. Parents are only permitted to make decisions of this nature with regard to their own lives and not those of their children.⁴¹⁸ Hence, when faced with these situations, courts need to continue to aggressively ensure that the interests and rights of the child to consent to or refuse medical treatment are protected against their parents' potentially debilitating beliefs.⁴¹⁹

⁴¹³ Section 129 (10) of the Children's Act 38 of 2005.

⁴¹⁴ Artificial blood used for transfusions are expensive for some families to afford and thus, cannot resort to this alternative. The transmission of artificial blood also has the potential to cause additional health problems.

⁴¹⁵ Hartsell (note 380 above; 516).

⁴¹⁶ *Ibid* at 506.

⁴¹⁷ Diaz (note 379 above; 87). Currently, only some states of the United States have statutory exemptions that allow parents to assert their religious beliefs as a defence to murder.

⁴¹⁸ *Ibid* at 86.

⁴¹⁹ *Ibid*.

6.3. Children who refuse medical treatment on religious grounds: Foreign case law

The Constitution declares that everyone has the right to freedom of conscience, religion, thought, belief and opinion illustrating that everyone, adult or minor, is permitted to exercise this right as they wish and as prescribed by their religion;⁴²⁰ even if it entails refusing life-saving medical treatment due to religious creeds. Decisions to refuse medical treatment based on religious indoctrinations are not only taken by parents. Although not welcomed by parents and health care practitioners, children who are firmly grounded in their faith also refuse medical treatment for themselves. In this event, parents and healthcare practitioners usually respond to such refusal with resounding negativity by instituting legal intervention compelling the child to undergo the medical treatment that has unwaveringly been refused.

It has become apparent that the situations in which legal intervention has been prompted by a child's refusal of medical treatment fall into one of three categories. The first situation arises where treatment has been refused by a minor who is mentally ill or mentally disturbed rendering such refusal invalid as he or she lacks the capacity to provide a valid refusal.⁴²¹ In this category, minors are afflicted with defects in their ability to comprehend, reason and make meticulous decisions justifying the commission of coerced medical treatment.⁴²² Secondly, children are habitually coerced to submit to treatment by legal interference despite the fact that they are mature and competent enough to refuse medical treatment for their own reasons. Such submission, as debated in a preceding chapter, cannot and should not be justified once the child has proven to be sufficiently mature to refuse treatment. Of particular relevance to this discussion, refusals of medical treatment are incited by a religious belief, held by a child, that denounces the prescribed method of treatment.⁴²³ Children belonging to this category do not have an impaired ability to reason, understand and make competent decisions. They are mature and have the capacity to make well thought decisions, similarly to children belonging to category

⁴²⁰ Section 15 (1) of the Constitution of the Republic of South Africa, 1996.

⁴²¹ Bridge (note 412 above; 585).

⁴²² Ibid.

⁴²³ Ibid.

two.⁴²⁴ Basing a refusal of medical treatment upon a sincerely held religious belief that would undoubtedly be accepted had the refusal been made by a person enjoying major status,⁴²⁵ should equally be accepted by a mature and competent child making a refusal of the like.⁴²⁶ What follows is an analysis of the foreign law cases of *Re L (Medical Treatment: Gillick Competency)*⁴²⁷ and *In Re E.G. (Ernestine Gregory)*⁴²⁸ which will be used in order to make recommendations for the South African position governing refusals of medical treatment by children based on religious beliefs.

6.3.1. *Re L (Medical Treatment: Gillick Competency)*

The High Court in *Re L* had occasion to consider whether to sanction surgical intervention inclusive of blood transfusions with the intention of saving the life of a 14 year old girl, or support her refusal to accept medical treatment.⁴²⁹ Following in the footsteps of her parents, L was a devoted Jehovah's Witness who had suffered from epilepsy.⁴³⁰ She had fallen, fully clothed, into a bath of hot water resulting in burns on 54 percent of her body surface with 40 percent of those burns being third degree burns.⁴³¹ According to the expert opinion of a burns consultant, L's injuries were so severe that it required three operations that were essential for her survival.⁴³² These operations required blood transfusions to which L had expressly indicated, both verbally as well as in the form of her 'no blood card'⁴³³ that she was not be given any blood in the event that she may need them if she sustained injuries.⁴³⁴ Doctors had confirmed that the medical treatment would provide a 'very optimistic' chance of survival, whereas without the treatment, L would succumb to her injuries after a fatal onset of gangrene - this end had not been

⁴²⁴ Ibid at 586.

⁴²⁵ Eighteen years of age.

⁴²⁶ Bridge (note 412 above; 586).

⁴²⁷ (1998) 2 FLR 810.

⁴²⁸ (1989) N.E.2d 549 322.

⁴²⁹ *Re L* supra note 427 at 810.

⁴³⁰ *Re L* supra.

⁴³¹ *Re L* supra.

⁴³² *Re L* supra.

⁴³³ This is also known as an 'Advanced Medical Directive/Release Form' which had been signed by L, in which she had indicated that she does not wish to receive any blood transfusions if the need arose.

⁴³⁴ *Re L* supra note 427 at 810. These wishes had been reaffirmed by L two months before her incident.

disclosed to her.⁴³⁵ Despite L's adamant refusal of medical treatment, the hospital had successfully sought an order for the administration of blood and blood products during the progression of treatment without L's consent.⁴³⁶ This order sparked a legally controversial dilemma that was only resolvable upon a balance of the minor's right to religion coupled with her degree of understanding, competence and maturity.⁴³⁷

The court's deliberation on L's capacity to refuse treatment had been a thorough one, beginning with detailed knowledge about the background of her religious faith.⁴³⁸ An assessment conducted by a child psychiatrist revealed that L had embraced all that her religion had required of her wholeheartedly, unashamedly, and most significantly, by her own will.⁴³⁹ Evidence had been led by the child psychiatrist that L's faith was 'strongly held',⁴⁴⁰ without being subjected to the influence of her parents or stepfather as there was no indication that they forced her to maintain her refusal.⁴⁴¹ This verifies that the decision to refuse treatment had been that of L alone - a decision, based on her life enduring religious belief that is her right to make. Decisions founded upon religious principles must remain a right belonging to a mature and competent child as liberally as it belongs to an adult, without undermining it in any manner⁴⁴² - these decisions must be upheld as swiftly as it is when adults are concerned. Unfortunately, L's wishes had not been granted the respect that it had deserved due to an incongruous finding of incompetence.

Subsequent to assessing L's competence, the court found that she had lacked competence to refuse medical treatment for two reasons. The first reason pertained to the fact that her ardent religious lifestyle had also been a sheltered one, depriving her of the experience of life; thus,

⁴³⁵ *Re L supra*.

⁴³⁶ *Re L supra*.

⁴³⁷ Bridge (note 412 above; 587).

⁴³⁸ L had been described as a mature model of a young person who did not pursue the worldly desires and undisciplined interests that are usually pursued by youth; instead, she had devoted her time addressing matters of the church.⁴³⁸ She was a 'well regarded and popular' girl who had been well received and supported by the Jehovah's Witness parishioners. See *Re L supra* note 427 at 813.

⁴³⁹ Bridge (note 412 above; 587).

⁴⁴⁰ *Re L supra* note 427 at 812.

⁴⁴¹ Bridge (note 412 above; 587). On the contrary, statements by the stepfather revealed the family's support for whatever order the court had decided to make. This indicates an acceptance of an order to administer treatment to L.

⁴⁴² *Ibid* at 589.

limiting it.⁴⁴³ The other implausible reason that gave rise to a finding of incompetence was that L was ‘not able to be given all the details’ necessary to make a competent decision.⁴⁴⁴ Hereof, the court stated:

‘[Her religious lifestyle] necessarily limits her understanding of matters which are as grave as her own present situation. It may be that because of her belief she is willing to say, and to mean it, ‘I am willing to accept death rather than to have a blood transfusion’, but it is clear in this case that she has not been able to be given all the details which it would be right and appropriate to have in mind when making such a decision.’⁴⁴⁵

The first inference drawn is that her rigid religious dedication has limited her ability to make a decision based on her right to religious belief.⁴⁴⁶ The court attributed this to the fact that children uncompromisingly adopt their religious beliefs whereas adults would be willing to change their position by a process of reasoning and the use of life experience, therefore, it is only adults whom are able to make competent decisions based on religious obligations.⁴⁴⁷ On the contrary, it is submitted, that possessing absolute belief without being fickle minded and easily persuaded to turn one’s back on one’s faith, are the very essence of religious belief.⁴⁴⁸ Deep religious faith is not only properly acquired with the passage of time and defies all reasoning, rationality, intelligence, understanding, maturity and developed cognitive functioning. All of which the High Court had erroneously suggested in *Re L*.⁴⁴⁹ All of these qualities are irrelevant to and should not be used as the basis for assessing the competence of children to make a religiously sound decision.⁴⁵⁰ In actual fact, relying on this reasoning, children would be far more well-equipped to make a religiously sound decision than adults would, considering that they possess an unwavering belief in their faith that defies rationality and reasoning that adults unnecessarily attach to their religious belief – which are the very attributes that are alien to religious belief.⁴⁵¹

⁴⁴³ Ibid at 590.

⁴⁴⁴ *Re L* supra note 427 at 813.

⁴⁴⁵ *Re L* supra.

⁴⁴⁶ Bridge (note 412 above; 590).

⁴⁴⁷ Ibid at 588.

⁴⁴⁸ Ibid.

⁴⁴⁹ Ibid at 589.

⁴⁵⁰ Ibid.

⁴⁵¹ Ibid.

This confirms that children have the right to make decisions based on their religious teachings and should, without intervention, be permitted to do so.

The second inference is that the court had denied L's competence on the deliberate concealment of information conveyed to her by her family, doctor, as well as hospital staff who did not deem it necessary to inform L about the consequences of refusing a blood transfusion in that her refusal would lead to fatal gangrene.⁴⁵² This omission of information indicates that L had lacked vital information, without which, she was unable to fully understand her predicament and make a decision acceptable by the court. L was denied the right to make an informed refusal through no fault of hers.⁴⁵³ The fact that L had not been informed of the risks of her decision shows that she had been deprived of her right to make a valid refusal as a decision made as a result of partial information cannot be a true decision.⁴⁵⁴ Due to this flaw that the court could have corrected by ordering that L receive the omitted information, she was denied competence because the court found that her understanding was eroded by defects.⁴⁵⁵ Although true, her understanding was not defective due to her own inherent defects but because she was denied the opportunity to make a competent decision due to the fault of the court. Therefore, a finding of incompetence in this case was a troubling error that should have instantaneously been rescinded.

Another disconcerting error was the court's statement that the same order of incompetence would have been granted had L been found to be competent.⁴⁵⁶ This cannot be so. This constitutes an unfair and blatant violation of a child's right to make autonomous decisions and to exercise their religious values without restrictions. If the outcome is already known by courts prior to embarking upon an assessment of competence, courts should not tediously apply a test of competence that clearly holds no significance or relevance to their judgement. If neither judges

⁴⁵² Ibid at 591.

⁴⁵³ Ibid.

⁴⁵⁴ Acknowledging that doctors are entitled to exercise their right of therapeutic privilege enabling them to conceal certain facts from patients as they are unable to cope with the obscured information, this cannot be said about L. There had been no inkling whatsoever that she would experience exacerbated anguish had she been fully cognisant of the risks. Ultimately, she was a mature and intelligent girl who had been willing and ready to face death, and any individual who has the ability to reach such an escalated level of mental and physical acceptance of their end has the competence to accept any information, regardless of how harrowing. See Bridge (note 412 above; 587 – 591).

⁴⁵⁵ Ibid at 591.

⁴⁵⁶ Ibid.

nor society are willing to permit children to ‘court unfavourable outcomes in judgements relating to medical treatment, we should say so openly.’⁴⁵⁷ Pretense assessments should not be conducted merely for the sake of complying with a legal requirement. These tests of competence are the ground upon which children may or may not be able to exercise their rights and must be conducted in all solemnity.

Unfortunately, the principles that South African Law can implement from this case is, bluntly, ‘what not to do.’ The decision reached in *Re L* was ‘undoubtedly incorrect’⁴⁵⁸ for three reasons. To begin with, the court’s first finding of incompetence was inspired by the fact that children, like L, hold staunch and unwavering faith in their religion that is unchanged by reasoning, rationality, intelligence and other cognitive functions that were believed by the court to only develop through a passage of time – including the development of religious belief. However, absolute faith and belief are the quintessence of religion, whereas rationality and reasoning are not. This means that children are able base their decisions on the right to religion in the purest manner and must not be deprived of doing so considering that religion is a right that everyone is eligible to exercise (children even more so, so it seems). Consequently, children are competent to and should be able to exercise their constitutional religious freedom in medical matters without question.

The court’s second finding of incompetence centered on their indiscretion that had successfully been passed off as that of L’s. Vital information had deliberately been concealed from L’s knowledge and the President of the Family Division did not wish to order the conferring of this information to her, despite the fact that such information was her right to receive and was material in order for her to be able to make an informed decision. To reach a valid and informed refusal, one must be cognisant of all material facts and risks and to be denied of such information means being denied of your right to make informed decisions. All information significant to reaching a competent decision must be provided to children, as they are provided to adults. If an omission of information does occur, a finding of incompetence cannot be made in the first place.

⁴⁵⁷ M Brazier & C Bridge ‘Coercion or Caring: Analysing Adolescent Autonomy’ (1996) 16 (1) *LS* 101.

⁴⁵⁸ Bridge (note 412 above; 594).

The concluding finding that cannot hold a place in South African Law is that assessing competence is insignificant. Competence determines whether or not a child is able to exercise their rights as most legal functions that could be performed by children require a prior finding of competence, making this assessment the center of children's rights. As a result, if a child in question displays the requisite competence; he or she must be able to carry out their rights. In this case, competent children must be able to make a religious refusal of medical treatment.

6.3.2. *In Re E.G. (Ernestine Gregory)*

A young girl suffering from acute leukemia required chemotherapy treatment which additionally required several blood transfusions.⁴⁵⁹ Ernestine, together with her mother, had refused these transfusions as they were contrary to Ernestine's religious canons as a Jehovah's Witness.⁴⁶⁰ The court responded to Ernestine's refusal by ordering blood transfusions; however, this order had been overturned when the appellate court had found that she was a 'mature minor' who was sufficiently competent to refuse medical treatment, even if the result was fatal, as she had merely been exercising her right to the freedom of religion.⁴⁶¹ The Illinois Supreme Court had further affirmed this finding while confronted with the question of whether or not a child would ever be afforded the right to refuse life-saving medical treatment.⁴⁶² To answer this paramount question, the court had deemed it necessary to assess the competence, decision-making capabilities and maturity levels of Ernestine and for this referred to testimony by her treating medical practitioner who had confirmed that she was a competent minor who understood the consequences of accepting as well as rejecting treatment.⁴⁶³ He had further expressed that he was impressed with her level of maturity and her ardor for her religious beliefs.⁴⁶⁴ In favour of Ernestine refusing treatment was a psychiatrist who had assessed her decisional capacity and concluded that it had

⁴⁵⁹ Harvey (note 64 above; 301).

⁴⁶⁰ Ibid. The court had responded to Ernestine's mother's refusal by equating it to neglect.

⁴⁶¹ *Re E.G.* supra note 428 at 324.

⁴⁶² *Re E.G. supra* 325.

⁴⁶³ *Re E.G. supra* 323-324.

⁴⁶⁴ *Re E.G. supra* 324.

been that of an adult.⁴⁶⁵ On the basis of these testaments, the court established that mature minors, like Ernestine, have a right to refuse medical treatment.⁴⁶⁶

The principles that emanate from this case will make a positively momentous impact if adopted by South African Medical Law. This case emphasizes that the constitutionally guaranteed right to exercise religious freedom belongs to minors inasmuch as it belongs to adults. Evaluating competence is crucial in determining whether or not children are amply mature to refuse medical treatment based on religious instructions and should not be precluded from doing so if their competence has been established by ‘clear and convincing evidence’⁴⁶⁷ that the child in question is a mature minor capable of making a ‘mature, reflective and weighty decision.’⁴⁶⁸

6.4. Conclusion

The Constitution of the Republic of South Africa declares that everyone has the right to freedom of conscience, religion, thought, belief and opinion illustrating that everyone, adult or minor, is permitted to exercise this right as they wish and as prescribed by their religion.⁴⁶⁹ This right entails refusing life-saving medical treatment if one’s religious beliefs require it. Children are as equally entitled to the enjoyment of this right as adults are. Therefore, it is submitted, when a child who is competent to understand what a refusal medical treatment entails, such refusal must not be overturned. Compelling an unwilling competent child to undergo medical treatment that his or her religious beliefs prohibits infringes his or her constitutional right to right to freedom of conscience, religion, thought, belief and opinion.

Due to the lack of legislation governing refusals of medical treatment by children, foreign case law was used to illustrate the principles that South African Law should consider. The case of *Re*

⁴⁶⁵ *Re E.G. supra.*

⁴⁶⁶ *Re E.G. supra* 325.

⁴⁶⁷ *Re E.G. supra* 327. The court considered the testimonies provided by the attending physician as well as the psychiatrist as ‘clear and convincing evidence’ of Ernestine’s maturity and competence, and relied on this evidence when deciding the case. In *Re Long Island Jewish Medical Center* (1990) 557 N.Y.S.2d (N.Y. Sup. Ct.) the court had ruled against a minor’s refusal of medical treatment due to the absence of clear and convincing evidence of his ability to make a mature decision.

⁴⁶⁸ In *Re Long Island Jewish Medical Center* (1990) 557 N.Y.S.2d (N.Y. Sup. Ct.) 241-243.

⁴⁶⁹ Section 15 (1) of the Constitution of the Republic of South Africa, 1996.

L, had stressed the importance of assessing the competence of children to refuse medical treatment. Competence determines whether or not a child is able to exercise their rights. Therefore, if a child displays the requisite competence; he or she must be able to carry out their rights. It is submitted that competent children must be able to make a religious refusal of medical treatment without their decisions being overruled. The case concluded that children are able base their decisions on the right to religion in the purest manner and must not be deprived of doing so.

The case of *Re E.G.* also emphasizes the importance of establishing the competence of a child to refuse medical treatment. The court stated that once competence has been established by ‘clear and convincing evidence’⁴⁷⁰ that the child in question is a mature minor capable of making a ‘mature, reflective and weighty decision,’⁴⁷¹ a refusal of medical treatment by the child must be respected.

It is submitted that when faced with a child’s refusal of medical treatment based on religious grounds, assessing the competence of the child to make such refusal is vital. Children who possess competence deserve to have their refusal of religiously prohibited medical treatment respected, considering that religion is a right that everyone is entitled to exercise.

⁴⁷⁰ *Re E.G.* supra note 428 at 327. See footnote 467.

⁴⁷¹ In *Re Long Island Jewish Medical Center* (1990) 557 N.Y.S.2d (N.Y. Sup. Ct.) 241-243.

CHAPTER SEVEN

Conclusion and Recommendations

7.1. Concluding remarks and recommendations

While South Africa continues to make significant progress in many areas, there are areas, such as children's rights, which need ongoing review and evaluation. This had been done once when the Child Care Act was reviewed and subsequently repealed by the Children's Act. The submission in this dissertation is that another review is needed; a review of the Children's Act, and in particular, of section 129 (2).

The consent to medical treatment by children is governed by section 129 (2) of the Children's Act. The approach taken in this dissertation is that the corollary right of the right to consent to medical treatment, is the right to refuse medical treatment. However, due to the fact that the Children's Act fails to recognise and make provision for the converse of the right to consent to medical treatment, the right of children to refuse medical treatment has been inferred from section 129 (2). The right of children to refuse medical treatment is a significant right and it is not sufficient that this right be inferred from another right. The right to refuse medical treatment by children is in need of a place of its own in the Children's Act, even if it is included as a part of section 129 (2). Therefore, it is recommended that the right to refuse medical treatment by children be clearly included in the Children's Act in order for children to have a salient right to refuse medical treatment.

When enacting the right to refuse medical treatment, inspiration can be drawn from section 129 (2), which allows children to consent to medical treatment, considering that refusal is the counter-coin of consent. However, in order to do this, section 129 (2) must first be altered. Section 129 (2) gives children the right to consent to (and the inferred right to refuse) medical treatment, provided that they meet the requirements stipulated in the section. Section 129 (2)

states that a child may consent to his or her own medical treatment if the child is over the age of 12 years and is of sufficient maturity and has the mental capacity to understand the benefits, risks, social, and other implications of the treatment. As discussed in chapter three, section 129 (2) uses a ‘combined-approach’ in order for children to be eligible to consent to or refuse medical treatment; the child must be over the age of 12 years *and* be competent. The Choice Act, however, does not require the attainment of a certain age in order for minors to consent to or refuse to consent to a termination of pregnancy. It is recommended that the Children’s Act follow suit and mould the legislation closely akin to the Choice Act to allow children, regardless of age, to refuse consent to medical treatment as long as they are competent and capable of doing so. The manner in which the Children’s Act should read is as follows:

A child may consent to or refuse consent to his or her own medical treatment if the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social, and other implications of receiving the treatment, or of not receiving the treatment.

This means that the approach that is to be adopted by the Children’s Act should focus on maturity as a test for competence. Age should not form part of the basis of a test to establish competence. Where the legislation requires the presence of ‘sufficient maturity’ and ‘mental capacity,’ this dissertation has recommended two approaches that the Children’s Act should adopt in order to determine whether children are sufficiently mature and competent to refuse medical treatment.

The first approach is the ‘Mature Minor’ doctrine which stipulates that children who have the ability to understand the nature, risks, and consequences of refusing medical treatment are entitled to refuse medical treatment despite disagreement from parents or other third parties. Children who satisfy the doctrine display a sufficient level of maturity and ought to have their decisions respected by others, irrespective of their age. This doctrine focuses on the maturity of the child rather than on the child’s age. According to the foreign cases that have applied this doctrine, the courts had done so on a case-by-case basis acknowledging that competence is a subjective concept requiring subjective testing. The competence of children to refuse medical treatment differs from child to child and is based on their level of maturity and not on their age.

These cases have frowned upon the use of strict age limits to determine competence to refuse medical treatment.

The second approach, which is of similar nature to the ‘Mature Minor’ doctrine, is the principle of ‘Gillick competence’. The court in the *Gillick* case had stated that the essence of this principle was that children may consent to treatment if they are ‘normally intelligent and [are] reasonably capable of assessing the advantages and disadvantages of the proposed treatment and providing effective consent to such treatment.’⁴⁷² The principle of ‘Gillick competence’ applies to refusals of medical treatment as well. Thus, the ability to refuse treatment will depend on the child’s maturity and understanding, and not on the child’s age. The judge in the *Gillick* case had confirmed that once a decision has been made by a Gillick competent child, this decision cannot be disrespected by interference by parents or other third parties as parental decision-making authority ends when the child demonstrates sufficient understanding and intelligence as well as sufficient intellectual and emotional maturity.

It is recommended that the ‘Mature Minor’ doctrine and the principle of ‘Gillick competence’ be adopted by the Children’s Act as tests to determine whether or not a child is competent to refuse medical treatment. Once a child proves to be competent to refuse medical treatment, this refusal is deserving of respect by all and must be upheld.

Once the age limit prescribed by the Children’s Act has been removed and the right to refuse medical treatment has been provided for as recommended, the only test by which to determine the competence of children to refuse medical treatment will be the assessment of maturity. The ‘Mature Minor’ doctrine and the principle of ‘Gillick competence’ have already been recommended as methods to determine maturity. However, there must also be a manner by which these maturity assessments are to be made and the Children’s Act does not prescribe the means of ascertaining whether children are ‘sufficiently mature’ or possess the necessary ‘mental capacity’ to refuse medical treatment. Thus, it is submitted, that there is a need for the Children’s Act to prescribe a test by which to make maturity determinations. There are two methods that have been recommended which would assist healthcare professionals and parents as well as courts in determining whether or not a child is sufficiently mature and competent to

⁴⁷² *Gillick* supra note 168 at 374.

refuse treatment. These methods would also bring understanding of why a child in question chooses to refuse medical treatment.

The first method entails explaining, to the child, the nature, extent, risks and obligations of the medical treatment as well as the effects and consequences of refusing it. Thereafter, the child should be asked to paraphrase what has been explained to him or her in order to determine whether the child has understood the nature and consequences of their decision. This would simply allow one to determine whether or not children ‘know what they are doing’ when they express adamant refusals of medical treatment. In addition, the child must be asked a series of questions that are suitable for evaluating a child’s ability to refuse medical treatment. To assist in this endeavor, questions relating to the child’s suffering, discomforts, and effects of medical treatment will reveal the child’s ability to understand the nature of their malady. Questions about whether the child believes that there is a need for treatment, whether the child believes that there are benefits to be provided by treatment, or simply asking the child why they wish to refuse treatment analyse the child’s ability to understand the nature of the recommended treatment.

The second recommended method of assessing maturity emanates from the foreign case of *In re Moe*⁴⁷³ where the court considered various factors in order to assess the maturity level of children. The court considered the child’s tone of voice, expressions, and general demeanor; whether the child’s responses were well informed and articulate; the degree to which the child evaluated and made decisions based on relevant information and the child’s ability to understand the decision that he or she has made. It is recommended that these factors be adopted and elaborated upon by the South African legal system in order to devise an effective method of assessing the maturity of children to make competent refusals of medical treatment.

Adopting a clear and consistent method of evaluating the maturity and competence of children to refuse medical treatment requires a suitable professional to make this crucial assessment. Identifying the best suited professional to determine if a child in question possesses the necessary mental capacity and maturity to refuse medical treatment is an essential aspect of ensuring the accuracy of the results of the assessment of maturity. Therefore, it is submitted that child psychiatrists, or individuals who have been trained in cognition, child development or

⁴⁷³ (1981) 298 12 (Mass. App. Ct.) N.E.2d 1038 423.

behavioural medicine should be identified as the correct professionals to make maturity assessments. These individuals are specifically trained to make maturity assessments and evaluate the competence and development of children.

Once the maturity level of a child has been assessed and the presence of competence has been found by an appropriate professional using a prescribed method of assessing competence and maturity as recommended, it is submitted that the child's right to refuse medical treatment is worthy of respect and should not be overruled. This submission would bring equality in the exercise of children's rights and the rights afforded to adults. In other words, children will be able to exercise their rights in the same manner that adults do. The right of children to possess and fulfil their rights on the same platform as adults is implied by Section 7 (1) of the Constitution and the UDHR which affirm that all individuals are equal in dignity and rights. Applying these principles to the medical law context will allow children to have their refusals of medical treatment respected provided that they are competent just as the competent refusals of treatment made by adults are respected. Incompetent refusals by adults are overruled by virtue of their incompetence. Therefore, it is submitted that it is only when children show evidence of insufficient maturity and capacity to refuse medical treatment can such refusal be overruled.

Overruling the competent refusals of medical treatment made by children would infringe upon many of their rights, some of which have been discussed in this dissertation. The rights of children to participate in matters that affect them are governed by the CRC and the Children's Act. The provisions of these documents confer authority upon children to express their views in all matters concerning them and have those views considered in accordance with their age, maturity and development. Moreover, these provisions recognise that children have a separate 'voice' worthy of being heard and are not mere subjects of a third party's authority. Children who are competent to form views and express these views must be taken seriously, regardless of whether the views expressed are refusals of medical treatment.

The argument that has been thoroughly discussed and submitted in this dissertation is that children have the right to refuse medical treatment provided that they are sufficiently mature to understand the nature, risks, effects and consequences of a refusal of medical treatment. Once this level of competence has been attained, children should be permitted to refuse medical

treatment without the fear of their refusal being overruled by parents, healthcare professionals or courts. There is no justification for overruling a refusal of medical treatment that is a competent and informed refusal; the fact that a child has made this competent refusal is insignificant and should not be used as a ground to justify the overruling of a refusal. Should the refusal of treatment made by a competent child be overruled, this would infringe their right to refuse the medical treatment that their competence allows.

The constitutional right to bodily and psychological integrity that protects children from unauthorized interferences of their bodies will be infringed if medical treatment that has been refused is ordered to be performed on an unwilling child. The Choice Act realises the importance of the right of children to bodily and psychological integrity by allowing pregnant minors to make autonomous decisions regarding their bodies. The Choice Act declares that the pregnant minor alone has the right to decide whether or not to undergo a termination of pregnancy. The provisions of the Choice Act do not require the consent or involvement of any third party in the making of this decision, unless the minor is incompetent. It is submitted that the Children's Act adopt the same approach when a child refuses medical treatment by making the choice to refuse treatment the sole decision of the child, unless the child is incompetent to refuse treatment.

The Constitution and the Children's Act as well as other international and regional human rights conventions require that the best interests of the child be a paramount consideration in all matters concerning the child. However, the right of the child to be treated in accordance with their best interests is encroached upon when their competent refusals of medical treatment are overridden. Furthermore, it is not always in the best interests of children to enforce the administration of medical treatment. This is particularly so when the medical treatment is invasive, futile and offers little benefit to the child. In these circumstances, children should not be plagued with unwanted medical treatment and should be allowed to die in dignity. To compel medical treatment would be to violate the child's right to be treated in accordance with his or her best interests and would likewise violate his or her constitutional right to dignity and life.

The constitutional right to freedom of religion, belief and opinion permits children, similarly to adults, to refuse medical treatment that is prohibited by their religious beliefs. Medical treatment

that is inconsistent with religious beliefs should not be forced upon a child who has competently refused it, resulting in a violation of their constitutional right to religion, belief and opinion.

7.2. Summary of recommendations

1. The Children's Act must be reviewed in order to:
 - 1.1. Include the right to refuse medical treatment in the Act, even if it is included as part of section 129 (2);⁴⁷⁴
 - 1.2. Alter section 129 (2) to remove the age limit of 12 years and adopt an approach that only requires a child to be sufficiently mature and competent to provide a refusal of medical treatment. This should be done in like manner to the Choice Act;⁴⁷⁵
 - 1.3. Include an approach that focuses on maturity as a test for determining whether children are competent to refuse medical treatment; age should not form part of the basis of a test to establish competence. The 'Mature Minor' doctrine and the principle of 'Gillick competence' should be adopted as tests to determine whether children are competent to refuse medical treatment;⁴⁷⁶
 - 1.4. Develop and include a method of assessing the maturity and competence of children to refuse medical treatment. The first recommended method entailed asking children to paraphrase information about the medical treatment to determine if children understand the nature, effects and consequences of their refusals of treatment. The second recommended method requires the South African legal system to consider and elaborate upon the factors that the court had considered in the case of *In re Moe*;⁴⁷⁷
 - 1.5. Identify the best suited professional to assess the maturity levels of children to refuse treatment. Child psychiatrists or individuals who have been trained in cognition, child development or behavioural medicine have been recommended;⁴⁷⁸

⁴⁷⁴ This recommendation had been made in chapter three.

⁴⁷⁵ As discussed in chapter three.

⁴⁷⁶ These recommended approaches had been discussed in chapter three.

⁴⁷⁷ As recommended in chapter three.

⁴⁷⁸ These appropriate professionals had been recommended in chapter three.

2. Competent children should be afforded equal rights as adults and be permitted to exercise them as such. Competent refusals of medical treatment made by children should not be overruled as is the practice where competent adults are concerned;⁴⁷⁹
3. Overruling a competent refusal of medical treatment by a child would infringe his or her:
 - 3.1. Right to express his or her views and participate in matters affecting him or her in terms of section 10 of the Children’s Act and Article 12 of the CRC;⁴⁸⁰
 - 3.2. Right to bodily and psychological integrity in terms of section 12 of the Constitution and Article 8 of the European Convention on Human Rights;⁴⁸¹
 - 3.3. Right to be treated in accordance with his or her best interests according to section 28 (2) and section 9 of the Constitution and the Children’s Act respectively, as well as international and regional human rights conventions;⁴⁸²
 - 3.4. Right to dignity as provided for by section 10 of the constitution;⁴⁸³
 - 3.5. Right to life as prescribed by section 11 of the Constitution;⁴⁸⁴
 - 3.6. Right not to be treated or punished in a cruel, inhuman or degrading way as stated by section 12 (1) (e) of the Constitution;⁴⁸⁵
 - 3.7. Right to freedom of religion, belief and opinion in terms of section 15 of the Constitution.⁴⁸⁶

The consideration and implementation of these recommendations would constitute a step in the right direction towards giving effect to the significant right of children to refuse medical treatment. To illustrate the need to give effect to children’s rights, the words of Richard Farson⁴⁸⁷ are echoed:

‘Rights [must be granted to children] because without them children are incapacitated, oppressed and abused.’

⁴⁷⁹ This recommendation has been made and discussed throughout the dissertation.

⁴⁸⁰ As discussed in chapter two.

⁴⁸¹ As discussed in chapter four.

⁴⁸² As discussed in chapter five.

⁴⁸³ As discussed in chapter five.

⁴⁸⁴ As discussed in chapter five.

⁴⁸⁵ As discussed in chapter five.

⁴⁸⁶ As discussed in chapter six.

⁴⁸⁷ Richard Farson is a psychologist, author, and educator. He is the president and chief executive officer of the Western Behavioral Sciences Institute.

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