Blood transfusions: medical treatment or operation. Challenges encountered when balancing autonomy and religious beliefs with best interest standards

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Mini-Dissertation submitted in partial fulfilment of the requirements for the degree of Masters of Medical Law

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2024

DECLARATION REGARDING ORIGINALITY

I, Dr Nitinkumar Mohan Ghila, student number 953059479, hereby declare that the mini-dissertation entitled,

Blood transfusions: medical treatment or operation. Challenges encountered when balancing autonomy and religious beliefs with best interest standards,

is the result of my own research and has not been submitted in part or in full for any other degree or to any other university. All sources cited or quoted in this research paper are indicated and acknowledged with a comprehensive list of references.

Signed



Dr NM Ghila

Date: 29 November 2024

ACKNOWLEDGEMENTS

I would like to express heartfelt gratitude to my family and friends for their unwavering encouragement and support throughout this journey. Your belief in my potential inspired me to push forward.

To my late dad, for instilling in me the values, determination and resilience to always give my best and pursue excellence, irrespective of the challenges faced.

To my mum, thank you for your endless encouragement, patience, faith in me and for instilling in me the values, determination and resilience to always give my best and pursue excellence, irrespective of the challenges faced.

To my siblings, thank you for the invaluable support and keeping my spirits high.

A special thanks to my friends who stood by me, offering motivation and moments of reprieve. Your belief in my potential has inspired me to push forward.

ABSTRACT

Blood transfusions remain a cornerstone of modern medical practice and are an essential component in the management of patients in almost every field of clinical practice. There may be numerous challenges and requirements when blood transfusions are administered. It is therefore imperative to have a full comprehension of the legal aspects of administering a blood transfusion and how this may impact on adults and children. Prior to the commencement of any treatment, the patient needs to be part of the decision-making process. This mini-dissertation involves desktop research including both primary and secondary sources, on the legal and constitutional aspects of administering a blood transfusion. The rights based on religious beliefs and the right to refuse blood transfusions are discussed in the context of Jehovah's Witnesses. While acknowledgement is given to parents' rights to parenting and their rights to religious freedom and beliefs, the rights of children with rights to life, human dignity, healthcare, family or parental care must be balanced with the best interest standards. The study explores the rights of adults compared to children from the common law and constitutional aspects of consent and the autonomy of children in decision-making. It is conspicuous that the drafters of the Children's Act did not provide a clear delineation between medical and surgical treatment, a deficiency that carries substantial implications for the legal framework governing children's capacity to provide informed consent. A recommendation is made to address this deficiency in terms of amendments to section 129(3) of the Children's Act to include invasive treatment. Furthermore, amendments to the Children's Act should be made to include invasive procedures in subsections 129(5) to 129(10) alongside medical treatment and surgical operations, to enhance clarity and strengthen the protection of children's rights and best interests.

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CHAPTER 1: INTRODUCTION

1.1 Background

There has been significant progress with regards to children and adolescents and the right to make medical decisions in South Africa. The best interests of the child must be considered whenever decisions regarding treatment of a child are to be made. However, there is an extensive debate as to what circumstances a child or adolescent may refuse medical treatment, especially lifesaving treatment and if these decisions are against their best interests. While the rights to make medical decisions by a competent minor of consenting age are well established, such minors need to be duly assisted in cases of surgical treatment. The protection afforded to children regarding the right to refuse treatment is more limited than that afforded to adults. For instance, the rights of children to consent to or to refuse a blood transfusion based on religious grounds are not the same as the right established for adults. This differential approach to consent and refusal may not be necessarily justified, especially in a competent minor of consenting age. The autonomy of children with evolving capacity for decision-making becomes more relevant with advancing age and maturity, which subsequently comes into conflict with the rights of parents and medical practitioners who may consider the child's refusal as unreasonable. Furthermore, what constitutes medical treatment, surgery or operation in the Children's Act is not clearly distinguished.

This mini-dissertation is significant in that it considers the constitutional and medico-legal aspects regarding the administration of blood transfusions. It analyses whether the child's right to consent to treatment confers a similar right to refuse treatment, specifically with regards to blood transfusions. The study will also explore the rights of adults compared to those of children in the light of the common law and constitutional aspects of consent and the autonomy of children in decision-making. Furthermore, the best interest standards for children will be discussed from the perspective of regional and international jurisdictions. The right to refuse treatment will be discussed in the context of religious beliefs and the refusal of blood transfusions by Jehovah's Witnesses.

1.2 Introduction

In the words of Austrian American physician Karl Landsteiner, an immunologist who was best known for his groundbreaking contribution to the field of medicine and whose research revolutionised transfusion medicine:

> Without blood there is no life.
> Blood is a constant reminder of our mortality.
> Blood is precious resource that should never be taken for granted.
> The blood that flows through our veins is a reminder of our shared humanity.
> Blood binds families, communities and even nations together.
> Blood connects us all, regardless of race, nationality or background.
> Blood transfusion is a marvel of modern medicine.[1]

Blood transfusions remain a cornerstone of modern medical practice and are an essential component in the management of patients in almost every field of clinical practice. There are numerous challenges faced by medical practitioners administering blood transfusions in an evidenced-based manner while balancing the expected clinical benefit with the risks inherent in blood transfusions. This raises numerous medico-legal questions regarding blood transfusions related to the indication, risks and consent requirements. Moreover, the availability of alternatives to blood transfusions provides an alternative management strategy.

Prior to World War II, blood transfusions were considered a major surgical event and were only performed in a hospital setting under the supervision of surgeons.[2] However, when considering the current definitions available, the process of administering a blood transfusion may be regarded as a surgical treatment or operation as opposed to a medical treatment.

For the purposes of this mini-dissertation it is important to explore the challenges faced when administering a blood transfusion. It is imperative to have a full comprehension of the legal aspects of administering a blood transfusion, taking into consideration the implications for adults and children. While the right to consent or refuse treatment is recognised in competent adults, children are presumed to lack the capacity to make decisions alone regarding their own

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1 '30 Best Karl Landsteiner Quotes With Image', available at https://www.bookey.app/quote-author/karl-landsteiner, accessed 26 April 2024.

2 E T Monroe 'Blood transfusion' (1969) 73(2) *Dickenson Law Review* 201.

care and this presumption arises both in the common law and statutory law.[3] In this regard, the parents' right to consent to the treatment of children less than twelve years, or if they are over twelve years, but lack competency, is well recognised and such decisions are made in the best interests of the child.[4] This is in variance with the consent provisions in children above the age of twelve years under the Children's Act.[5] The Children's Act does not differentiate between the medical and surgical treatment. This lack of clarity has implications for the consent provisions of competent minors' rights to autonomy, especially on how blood transfusions may be regarded according to the current available definitions. No parent, guardian or caregiver can refuse treatment based on religious grounds unless there is a medical alternative for the medical treatment or surgical operation.[6] In this light, the major themes that are significant for the theoretical framework of this mini-dissertation are explored as follows:

1. The constitutional and legal aspects of when a blood transfusion is administered and the responsibilities of healthcare professionals.
2. The rights of adults versus children with regards to consent and refusal of treatment and the significance of the rights of a competent minor to participate in selected medical decisions.
3. How the right to autonomy influences decision-making based on the child's best interest standards, noting the consent provisions in the Children's Act regarding medical treatment and surgery, and the implications for consent when administering a blood transfusion to children.
4. The rights of adults based on religious beliefs and whether the child's right to consent or refuse a blood transfusion is equivalent to the rights of adults and the protection afforded to children.

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3 J Malherbe & A Govindjee 'A Question of Blood: Constitutional Perspectives on Decision-Making about Medical Treatment of Children of Jehovah's Witnesses' (2010) 73(1) *THRHR* 61.

4 S 7 of Children's Act 38 of 2005.

5 S 129 of Children's Act 38 of 2005.

6 S 129(10) of Children's Act 38 of 2005.

Currently, the use of blood and blood products are regulated by the National Health Act 61 of 2003 and associated Regulations.[7] In recent years, there have been significant concerns regarding the safety of, and necessity for, blood transfusions.[8] Concerns have arisen regarding consent and the right to refuse blood transfusions, the implications for healthcare professionals, and the role of the courts.[9] The availability of safe blood for transfusions remains essential in the management of patients in all spheres of medical practice.[10]

Prior to the commencement of any treatment, the patient needs to be part of the decision-making process, and a medical practitioner is mandated to obtain an informed consent. Without this, the practitioner may incur liability for civil action and a criminal charge of assault.[11] This principle is clearly enshrined in the South African Constitution[12] and the National Heath Act. Section 12(2) of the Constitution reaffirms 'that everyone has the right to bodily and psychological integrity, which includes the right to security and control over their body'. Therefore, all patients have the right to provide an informed consent or informed refusal in the healthcare context. The National Health Act clearly outlines the requirements for an informed consent by the patient or user.[13] Common law dictates that an informed consent must be comprehensive and extend to the entire transaction, which is inclusive of the consequences.[14] There is a duty on the healthcare practitioner to explain the procedures to be followed by the patient, the alternatives to the treatment, the benefits of the treatment, the risks of not abiding by the treatment, and the duty to warn the patient about the material risks involved in the proposed treatment.

Legal liability may result when the legal requirements for informed consent are not followed.[15] Failure to obtain the patient's lawful consent in violation of the *volenti non fit injuria* principle may expose the hospital and healthcare professionals to a civil action for assault, or a criminal charge of assault, civil action for *crimen injuria,* an action for breach of contract, or negligence, depending on the circumstances.[16] The provisions of the National Health Act, clearly set out

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7 GN R180 of GG 35099, 2 March 2012, as amended by GN 392 of GG 40816, 26 April 2017.

8 H Kramer 'Hazards of blood transfusion sparks conservation drive' (2001) 15 *Bloodless Medicine: supplement to Medical Chronicle* 15.

9 L Civin 'Blood transfusion and compelling orders' (1998) (June) *De Rebus* 52-56.

10 H Crookes 'Criteria for the acceptance and deferral of blood donors' (1999) *CME* 889.

11 S A Strauss *Doctor, patient and the Law: A selection of practical issues* (1980) 5.

12 S 12(2) of The Constitution of the Republic of South Africa, 1996.

13 S 6 and 7 of National Health Act 61 of 2003.

14 *Castell v De Greef* 1994 (4) SA 408 (C).

15 F F W Oosten *Doctrine of Informed Consent in Medical Law* (LLD Thesis, University of South Africa, 1989) 11.

16 M Slabbert 'Liability for the Transfusion of Blood in South Africa' (2006) 69(1) *THRHR* 41.

the requirements for providing treatment to patients. It also sets out the guidelines when an informed consent cannot be obtained and the role of proxies and other decision makers.[17] The Constitution clearly sets out the rights of patients. The Children's Act also specifies the parameters of consent for children under the age of eighteen years and specifies the consent provisions for children less than twelve years of age and those above the age of twelve.

It is a matter of frequent contention, whether the right to consent confers a similar right to refuse treatment by competent minors, and whether this right is the same as the rights afforded to adults to consent or refuse treatment, even in respect of life-threatening conditions or circumstances. The refusal of medical treatment is not included in the Children's Act but can be 'inferred from the wording'.[18] While the child may have the capacity to consent to medical treatment based on age, maturity and understanding, the ability to understand the treatment alone is not sufficient as the child must be able to understand the consequences and associated risks of accepting the treatment and the dangers of not accepting treatment.[19]

Difficulties may arise when there is a refusal of treatment by a child that may result in death or irreversible harm, when balancing the child's 'right to security in and control over their body' as stipulated in the Constitution (section 12(2)) and 'the best interests of the child' as set out in the Constitution (section 28(2)) and the Children's Act (section 9), respectively. It is submitted that the South African courts may be reluctant to overrule an 'informed refusal' made by a legally competent child despite an attempt by the parents or guardian of the child to do so in a court application.[20]

An important obligation of the healthcare professional is to inform the patients of their right to refuse treatment and to explain the implications, risks and obligations of such refusal. The question arises, whether the refusal by a competent minor of consenting age is deemed unreasonable and needs intervention by the courts or Minister of Social Development.[21] In South Africa, the High Court is the upper guardian in protecting children's rights and has broad discretion to intervene between parent and guardian. Although there is no specific list of special

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17 S 7(1)(b) of National Health Act 61 of 2003.

18 M Buchner-Even Leigh 'Is it a competent child's prerogative to refuse medical treatment' (2019) 52 *De Jure*, 242.

19 P Trowse 'Refusal of medical treatment-A child's prerogative?' (2010) 10(2) *QUTLJ* 206.

20 D McQuoid-Mason 'The National Health Act and refusal of consent to health services by children' (2006) 96 *SAMJ* 530.

21 D McQuoid-Mason 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse' (2010) 100(10) *SAMJ* 646.

circumstances in which such intervention may occur, the court may intervene in circumstances where the child's life, health or morals are threatened by parental authority.[22]

The right to health is recognised in numerous international and regional human rights instruments including the International Covenant on Economic, Social and Cultural Rights (ICESCR),[23] The Convention on the Rights of the Child (CRC),[24] and the African Charter on the Rights and Welfare of the Child[25] (African Charter), the South African Constitution[26] and the Children's Act.[27] The CRC emphasises the best interests of the child to be 'a primary consideration',[28] and state parties must allow a child who is capable of forming his or her own view, the right to express those views freely in all matters affecting the child,[29] and that 'state parties to respect the responsibilities, rights and duties of parents in a manner consistent with the evolving capacities of the child'.[30] However, the CRC does not expressly afford children of a certain level of maturity to independently make decisions, but it is suggested that this can be derived when Article 12 is read in conjunction with Article 5.[31]

Another prevalent theme in the literature is the discussion on the autonomy of children and the rights of a '*Gillick* competent' minor. There is conflict between the legal capacity of children and the powers of the medical profession or the judiciary to intervene. It is submitted that this is based on a partnership but not of equals.[32] Children have a right to parental care, and parenting involves providing care and making decisions for children and equipping them with the skills to make their own decisions.[33] In the case of younger children, the discretion of the parents remains 'unfettered'. However, older children have the right to be recognised.[34]

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22 B Clark 'My right to refuse consent: The meaning of consent in relation to children and medical treatment' (2001) 64 *THRHR* (2001) 605.

23 International Covenant on Economic, Social and Cultural Rights adopted 16 December 1966.

24 Convention on the Rights of the Child (CRC) adopted 20 November 1989.

25 African Charter on the Right and Welfare of the Child, adopted by OAU in 1990.

26 S 27 and S 28 of The Constitution of the Republic of South Africa, 1996.

27 S 11 of Children's Act 38 of 2005.

28 Article 3 of CRC.

29 Article 12(1) of CRC.

30 Article 5 of CRC.

31 H Kruger 'The Protection of Children's Right to Self-Determination in South African Law with Specific Reference to Medical Treatment and operations' (2018) 21 *PELJ* 15.

32 Clark (note 22 above; 606).

33 C Van der Westhuizen: 'Children as bearers of fundamental rights, and medical decision making' (1999) (63) *Responsa Meridiana* 63-65.

34 J Sloth-Nielson 'Ratification of the United Nations Convention on the rights of the child: Some implications for South African Law' (1995) (401) *SAJHR* 410.

The United Kingdom case of *Gillick v West Norfolk and Wisbech Area Health Authority and DHSS,*[35] encapsulates the extent and nature of the capability of the child to consent to medical treatment based on their evolving capacity. The '*Gillick* competent child' serves as a benchmark when ascertaining the capability of a child to consent to treatment. However, when a '*Gillick* competent child' refuses lifesaving medical treatment, it is recommended that doctors should approach the courts if the decision lacks rationality and logic. This is similar to the approach adopted by the South African Children's Act.

It is submitted that the right of a competent child to refuse treatment should apply in all cases.[36] However, the Court decisions in the United States, United Kingdom and in South Africa, which overrule a child's decision to refuse treatment, indicates that this right is not absolute or unlimited. The *Gillick* competency test recognises that childhood is a process of continuous change from newborn to adolescent and eventually adulthood and what is therefore regarded as a child's 'developmental trajectory'.[37] Moreover, the *Gillick case* confirms that 'nurturance and self-determination' are not mutually exclusive and that the stage of development of a child determines the approach to be taken. If the child is too young to have the capacity for rational thinking, then the 'nurturance' approach should be favoured and as the child advances in age, the child develops the capacity for rational thought and therefore the 'self-determination' approach becomes relevant.[38]

No decisions by children can be made without assessing the decision-making capacity of children based on developmental psychology alone. The cognitive (pertaining to the manner in which adolescents process information), and psychosocial differences (referring to deficiencies in adolescent's social and emotional capacities), between children and adults are well recognised. Furthermore, controversies have arisen whether the decision-making process in children, which may not be attributable solely to cognitive or to psychosocial factors but rather, may be regarded as a product of the interplay between two influences.[39]

The rights based on religious beliefs and the right to refuse blood transfusions are discussed extensively in the context of Jehovah's Witnesses who staunchly adhere to divine law and

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35 *Gillick v West Norfolk and Wisbech Area Health Authority and the DHSS* 1985 (3) All ER 402.

36 Committee on Economic, Social and Cultural Rights, general comment on the right to health (2000).

37 H Kruger 'The Protection of Children's Right to self-determination in South African Law with Specific Reference to Medical Treatment and Operations' (2018) 21 *PELJ* 6.

38 Ibid at 6.

39 E Caufmann E & L Steinberg '(Im)maturity of judgement in Adolescence: Why Adolescents may be less Culpable than Adults' 2000 *Behav Sc Law* 743.

respect 'man-made' law, especially that which reinforces divine law.[40] As previously mentioned, no parent, guardian and caregiver can refuse treatment based on religious grounds unless there is a 'medical alternative for medical treatment or surgical operation'[41] With regards to medical matters, Jehovah's Witnesses do not refuse medical treatment for themselves or their children but:

> they accept a vast majority of medical treatments, surgical and anaesthetic procedures, devices, techniques as well as haemostatic and therapeutic agents that do not contain blood products'.[42]

They do not ask for the 'right to die' but seek the right to choose 'non-blood medical treatment'.[43]

Throughout the world there are many instances of families where the religious convictions of the parents come into conflict with the rights and best interests of their children, especially in instances of parents who are Jehovah's Witnesses. When a child is born, the newborn does not choose his or her religion, and the child's religious beliefs are bestowed upon the child by their parents, and there is no concern about whether the choice of religion is in the best interests of the child. The issue arises as to whose rights prevail, and whether the parents' rights to parenting, religious freedom and belief supersede those of their children to life, human dignity, healthcare, family or parental care and the rights not to be neglected or abused.[44] Under South African common law, parents are regarded as the natural guardians of the child and bear the responsibility of making such decisions on their child's behalf.[45] Either parent, whether the mother or father, holds the authority to make decisions concerning the child's medical care and is required to act in the child's best interests, while being guided by the constitutional principles in their decision-making process.[46] There is a growing number of legal case reports that highlight parental authority in decision-making for their children, which comes into conflict when balancing a wide range of range of legitimate interests. This is clearly highlighted by the

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40 'Family Care and Medical Management for Jehovah's Witness' (1995), Watchtower Bible and Tract Society of New York Inc 4.

41 S 129(10) of Children's Act 38 of 2005.

42 Watchtower Bible and Tract (note 40 above; 4)

43 R K Spence … et al 'Transfusion and Surgery' (1993) Vol XX (12) *Current problems in Surgery* 1167.

44 B Bekink 'Parental religious freedom and the rights and best interest of children' (2003) 66 *THRHR* 246-265.

45 *Christian Education South Arica v Minister of Education* 2000 (4) SA 757 (CC).

46 S 28 of The Constitution of the Republic of South Africa, 1996.

case of *ES v AC*, where the parental right to freely practice one's religion without any form of discrimination came into conflict with the rights of the child.[47]

The limits of parental consent and refusal have been applied where the courts have ordered or permitted the treatment, or in instances of emergency under the doctrine of necessity to avoid death or serious injury.[48] As previously mentioned, it has been held that the state has the authority to intervene in the typical parent-child relationship for the protection of the child when ordering blood transfusions according to both the common law and statutory law. A similar approach has been adopted in the United States of America and the United Kingdom. Thus, the High Court in South Africa has held that the best interests of the child is the most crucial factor when considering competing rights and interests, and that the right to life cannot be overridden by parent's private religious beliefs.[49] This was subsequently codified in the Children's Act,[50] which addressed the consent provisions and a parent's or guardian's refusal to assist a child based on religious or other beliefs.

Human rights principles recognise the importance of protecting religious beliefs, especially within the realm of medical law. However, this protection is not absolute and subject to limitations.[51] International law has become increasingly influential in protecting children's rights and the South African Constitution specifically provides that the courts must consider international law (section 39.1.b) and may consider foreign law (section 39.1.c) where their laws have similar provisions to ours.[52] The numerous precedents in international jurisdictions are relevant and are instructive for decisions in the South African courts regarding the best interests of children and the refusal of blood transfusions by Jehovah's Witnesses.[53]

A noteworthy aspect of the Children's Act is that it does not clearly delineate between medical treatment and surgery. This has important implications for consent by minors when determining whether blood transfusions should be considered as medical treatment or as

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47 *ES v AC SA 57/2012* NASC 11 24 June 2015 in F Manyogana & M Slabbert 'A Jehovah's Witness's autonomy versus the interest of her children' (2018) 81 *Journal of Contemporary Roman-Dutch Law* 316-325.

48 *Glass v UK* 2004 (1) FCR 553.

49 *Hay v B* 2003 (3) SA 492 (W) 494.

50 S 129(10) of Children's Act 38 of 2005.

51 C O Niel 'Jehovah's Witness and Blood transfusion: An Analysis of Legal Protection Afforded to adults and Children in European/English Human Rights Contexts' (2017) 24 *European Journal of Health Law* 368-389.

52 S 39 of The Constitution of the Republic of South Africa, 1996.

53 D McQuoid-Mason & L Lotz, 'Religious beliefs and the refusal of blood transfusion for children: what should doctors do?' (2005) 68 *THRHR* 304.

surgery. The literature remains sparse in this respect. The Children's Act does not provide a definition of 'sufficient maturity' and there are no provisions that specify how the healthcare practitioner ought to assess a child's capacity to give an informed consent. This is compounded by the conspicuous lack of standardised tools for the assessment of decisional capacity.[54] The gap in the literature and legislation with respect to medical treatment and surgical operations requires to be narrowed to assist in informing policy and influencing the decision-making process, and recommendations need to be made for amendments to the relevant legislation so that there is no ambiguity. This mini-dissertation contributes to the debate and makes recommendations on whether amendments to the consent requirements for children are needed in the constitutional and legal framework to provide clarity regarding the meaning of medical treatment and surgery in the context of blood transfusions.

1.3 Purpose statement

This mini-dissertation embarks on an analysis of the medico-legal aspects of blood transfusions, whether current legislation is adequate, and whether more clarity is required for decision-making by children. It responds to the main research question of whether blood transfusions are regarded as medical treatment or surgical operations. It highlights the challenges encountered when balancing patient autonomy and parental religious beliefs with the best interest standards, specifically relating to children.

1.4 Research questions

To evaluate the research topic, the following research questions are addressed:

1.4.1 What are the constitutional and legal perspectives of blood transfusions?

1.4.2 Are competent children entitled to the same rights that are afforded to adults?

1.4.3 What are the best interest standards to be applied when balancing the rights to autonomy and refusal?

1.4.4 What are the rights and protection afforded to parents, guardians and caregivers based on religious beliefs?

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[54] W Ganya … et al 'Autonomy of the child in the South African context: Is a 12-year-old of sufficient maturity to consent to medical treatment?' (2016) 17 *BMC Medical Ethics* 66.

1.5 Conceptual framework

This mini-dissertation provides an informed perspective on decision-making by children compared to adults, and the right to autonomous decision-making by a competent child. Moreover, the rights to consent or refuse blood transfusions on the grounds of religion are discussed and the protection afforded to children in this respect.

1.6 Research methodology

The research involves desktop research on the legal and constitutional aspects of administering blood transfusions. The study explores the rights of adults compared to children from the common law and constitutional perspectives of consent and the autonomy of children for decision-making. The best interest standards for children will be discussed in comparative regional and international jurisdictions. The rights to refuse treatment based on religious beliefs will be discussed in the context of blood transfusions by Jehovah's Witnesses.

1.7 Blood transfusion: medical treatment or operation?

The numerous definitions of medical treatment and surgery or operation have an impact on how blood transfusions may be perceived, which is the reason for the complexity regarding the decision-making process in respect of children.

Loftus et al[55] noted in their review of the now repealed Child Care Act,[56] that that the drafters of the legislation had not provided clarity with regards to medical treatment and surgery in terms of section 39(4) of the Child Care Act. They highlight that any surgical procedure that is performed under a general anaesthetic is generally regarded as surgery, while any oral administration of medication is considered medical treatment and noted that a grey area existed between the two. The authors then proceed to list certain procedures that should be regarded as surgery, which they defined as:

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55 Loftus … et al 'Toestemming Deur Minderjariges: Die Grys Area Tussen Operasie en Mediese Behandeling' 1994 *De Rebus* 486; Cf. C Van der Westhuizen 'Medical treatment v surgery: Where does medical treatment end and surgery begin in terms of section 129 of the Children's Act?' 2018 39(3) *Obiter* 791- 802.

56 Child Care Act 74 of 1983.

> any surgical procedure that is performed under general or local anaesthetic for therapeutic and/or diagnostic purposes; and any procedure that entails the taking of tissue (excluding blood) by way of a needle or other instrument.

Moreover, they mention that medical treatment includes the administering of any medical substance inclusive of blood products, orally, intravenously, or in any other way. Medical treatment is also 'understood to include all procedures other than those requiring surgical intervention'.[57]

Wikipedia defines medical procedure as,

> a course of action intended to achieve a result in delivery of healthcare, which include therapeutic (i.e. intended to treat, cure or restore function or structure) such as surgical and physical rehabilitation.[58]

Wikipedia also defines surgery as,

> a medical speciality that uses manual and/or instrumental techniques to diagnose or treat pathological conditions, … to alter bodily functions, … to reconstruct or improve aesthetic and appearance, … or to remove unwanted tissues or foreign bodies. … The act of performing surgery may be called a surgical procedure or surgical operation.[59]

Medical treatment may also be regarded as 'an activity directed at or performed on an individual with the object of improving health, treating disease or injury or making a diagnosis'.[60] It may also be regarded as 'the act or conduct of diagnosis, treatment or operation'.[61]

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57 J Sloth-Nielsen 'Protection of Children' in C J Davel and A Skelton (eds) *Commentary on the Children's Act* (2007, revised in 2013) 63; Cf. C Van der Westhuizen 'Medical treatment v surgery: Where does medical treatment end and surgery begin in terms of section 129 of the Children's Act?' (2018) 39(3) *Obiter* 791- 802.

58 'Medical Procedure', available at, https://en.wikipedia.org/wiki/Medical procedure, accessed 19 March 2024.

59 'Surgical procedure', available at https://en.wikipedia.org/wiki/Surgery, accessed 19 March 2024.

60 *International Dictionary of Medicine and Biology* 229.

61 *Stedman's Medical Dictionary* 27th ed 1446.

The American Medical Association adopted the definition of surgery from the American College of Surgeons as,

> surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery is also the diagnostic or therapeutic treatment of condition or disease processes by any instruments causing localized alteration or transposition of live human tissue which includes lasers, ultrasound ionizing radiation, scalpels, probes and needles.[62]

Surgery may also be considered as 'branch of medicine which treats diseases, injuries and deformities by manual or operative methods'.[63]

Blood transfusions do not meet the criteria when surgery is regarded as 'medical treatment in which a person's body is cut open by a surgeon in order to treat or remove the problem part'.[64] Neither does the process of administering a blood transfusion necessarily meet the definition of operation, namely, 'any act performed with instruments or by the hands of a surgeon or any effect produced by an agent employed in therapy',[65] or 'any form of surgical procedure major enough to require anaesthesia'.[66] When one considers the definition of 'healthcare', which is defined as 'the maintenance or improvement of health via the prevention, diagnosis and treatment of disease, illness, injury and other physical and mental impairment in the patient'[67] and 'medical treatment' referred to as 'care in terms of medication, nursing and any other therapy designed to cure a disorder',[68] or 'any measure that is taken to prevent or cure a disease or disorder or to relieve symptoms'.[69] These definitions do not delineate between broadly described treatments which may be inclusive of surgical treatment.

In the case of *In re Fetus Brown*,[70] the court considered blood transfusions as 'an invasive medical procedure that interrupts a competent adult's bodily integrity and therefore should be regarded as an operation rather than treatment'. While this judgement applied to adults, there

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62 AMA Definition of Surgery H-475.983. Adopted from American College of Surgeons Statement ST-11.
63 *Dorlands Illustrated Medical Dictionary, Elsevier* (2005) 1278.
64 *Collins English Dictionary* (2005) 834.
65 *Dorlands Illustrated Medical Dictionary* (2005) 924.
66 *Harrap's Dictionary Medicine and Health London*: Harrap 1988 268; 395.
67 'Health care', available at, https://en.wikipedia.org/wiki/ Health care, accessed 26th April 2024.
68 *Harrap's Dictionary of Medicine and Health. London: Harrap Ltd* 1988, 395.
69 T Border *British Medical Association Illustrated Medical Dictionary*, London: BMA 2007, 559.
70 *In re Fetus Brown* 689 NE 2d 397.

is no reason that this should not apply equally to minors based on the rights of minors as determined by legislation and the constitutional rights of children.

Based on the above variable definitions, how blood transfusions are defined has important implications for consent especially regarding children. It is mandatory that there is compliance with legislation when blood and blood products are administered.[71] These legislative requirements apply both equally to adults and children. The next chapter will consider the constitutional and legal aspects when blood transfusions are administered. Relevant consent provisions for adults and children with associated medico-legal implications for the healthcare professionals will be expanded on in the context of rights of children, religious beliefs, patient autonomy and the best interests of the child.

1.8 Chapter breakdown

Chapter 1: Introduction

Chapter one introduces the mini-dissertation topic and discusses the legal aspects when a blood transfusion is administered. The responsibilities of, and the medico-legal implications for, healthcare professionals are discussed in the context of current legislative requirements. The chapter considers key terms and definitions regarding medical treatment and surgical operations and highlights the implications for consent by children.

Chapter 2: South African law and blood transfusions

Chapter two explores the constitutional and legal framework for consent and refusal of treatment by adults and children. The chapter discusses the rights of children and the best interests of the child standards, taking into consideration South African legislation, international and regional conventions and charters and case law.

Chapter 3: Comparative law and blood transfusions

Chapter three discusses the rights of adults based on religious beliefs in comparative jurisdictions, and whether in certain jurisdictions a child's right to consent or refuse treatment is equivalent to the rights of adults. The chapter considers, on a comparative basis, parental rights and responsibilities, parental rights to religious beliefs and the refusal of consent by children based on these beliefs. It also explores the comparative protection afforded to children

[71] National Health Act 61 of 2003.

based on the best interests of the standards and compares them with the position in South Africa.

Chapter 4: Blood transfusions and children

Chapter four discusses the rights to autonomy of children in decision-making based on competency, maturity and age. The chapter explores the implications for consent when administering a blood transfusion to children who are legally competent to give consent, and those who are not legally competent.

Chapter 5: Conclusion

Chapter five concludes by outlining the major issues and making recommendations based on the on the mini-dissertation's desktop research findings.

CHAPTER 2: SOUTH AFRICAN LAW AND BLOOD TRANSFUSIONS

2.1 Introduction

This chapter explores the constitutional and legal framework for consent. The rights of adults and children are discussed in the realm of constitutional rights and freedoms which have significant implications for children. The regulation of blood and blood products apply equally to both adults and children, however the rights of children to make decisions regarding treatment may not be the same. The chapter discusses the rights of children and best interest standards taking into consideration the South African legislation, international conventions and charters and case law.

2.2 Regulation regarding blood and blood products

2.2.1 National Health Act and Regulations

The use of blood and blood products are regulated by the Chapter 8 of the National Health Act 61 of 2003 (NHA)[72] and Regulations regarding the General Control of Human Bodies, Tissue, Blood, Blood Products and Gametes (Regulations).[73] The Minister of Health may make regulations[74] relating to tissue, cells, organs, blood, blood products and gametes, the production, packaging, sealing, labelling, storage and supplying of therapeutic, diagnostic and prophylactic substances from tissue.[75] This is also applicable to the supply of tissue, organs, oocytes, human stem cells and other human cells, blood, blood products or gametes;[76] the importation and exportation of tissue, human cells, blood, blood products or gametes;[77] the withdrawal of blood from living persons and the preservation, testing, processing, supply or disposal of withdrawn or imported blood;[78] the administering of blood and any blood product

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72 Chapter 8 of National Health Act 61of 2003.
73 Regulations regarding the General Control of Human Bodies, Tissue, Blood, Blood Products and Gametes Published under GN R180 in GG 35099 of 2 March 2012, as amended by GN 392 in GG 40816 of 26 April 2017.
74 S 68 of National Health Act 61 of 2003.
75 S 68(e) of National Health Act 61 of 2003.
76 S 68(f) of National Health Act 61 of 2003.
77 S 68(g) of National Health Act 61 of 2003.
78 S 68(h) of National Health Act 61 of 2003.

to living persons;[79] the production, packaging, sealing, labelling and supplying of blood and blood products.[80]

The Regulations also set out the provisions for the removal of blood products from a living person with written consent and in accordance to a prescribed manner,[81] and for the use of blood or blood products only for medical or dental purposes as prescribed.[82] No blood or gametes may be removed or withdrawn from a person who is mentally ill[83] or persons younger than eighteen years of age.[84] Only a registered medical practitioner, dentist or person acting under the supervision or instruction of a medical practitioner or dentist may administer blood or blood products for a living person.[85] No person or any authorised institution, may receive any payment in respect of the importation, export or acquisition for the supply to another person of blood or a blood product. The amount of payment contemplated may not exceed an amount which is reasonably required to cover the costs involved in the importation, export, acquisition or supply of the tissue, gamete, blood or blood product in question.[86] It is an offence for a person who has donated blood or a blood product to receive any form of financial or other reward for such donation, except for the reimbursement of reasonable costs incurred by him or her to provide such donation. It also is an offence to sell or trade blood or blood products and failure of compliance with the provisions of the NHA would result in a fine and/or imprisonment not exceeding five years.

It is stipulated that blood and blood products may be donated to any prescribed institution or person for any legitimate reason as per the NHA.[87] With regards to deceased persons, donation may only be made for the purposes of the training of students in health sciences, the purposes of health research, the purposes of the advancement of health sciences, therapeutic purposes, including the use of tissue in any living person, or the production of a therapeutic, diagnostic or prophylactic substance.[88] The NHA does not apply to the preparation of the body of a

79 S 68(i) of National Health Act 61 of 2003.
80 S 68(j) of National Health Act 61 of 2003.
81 S 55 of National health Act 61 of 2003.
82 S 56(1) of National Health Act 61 of 2003.
83 S 56(2)(i) of National Health Act 61 of 2003.
84 S 56(2) of National Health Act 61 of 2003.
85 S 59(2) of National Health Act 61 of 2003.
86 S (60) of National Health Act 61 of 2003.
87 S 63 of National Health Act 61 of 2003.
88 S 64(1) (a-e) of National Health Act 61 of 2003.

deceased person for the purposes of embalming, whether the process involve making incisions in the body for the withdrawal of blood and the replacement thereof by a preservative.[89]

Other than a person who has been:

> exempted as permitted by or under any other law, acquires, uses or supplies a body of a deceased person or any tissue, blood or gamete of a living or deceased person in any other manner or for any other purpose than that permitted.[90]

Failure and refusal to comply to the best of her or his ability with any demand, requirement or order of a health officer or a health officer of blood transfusion services[91] or hinders any person in the performance of her or his duties[92] in terms of the NHA and Regulations would be regarded as being guilty of an offence and would be liable on conviction to a fine or imprisonment for a period of ten years or to both fine and imprisonment.[93]

The Regulations set out the requirements regarding the licensing[94] and oversight[95] of national blood transfusion service, the appointment of health officers[96] and their duties,[97] the requirements of blood transfusion service,[98] and the recruitment of blood donors.[99] It also sets out mandatory testing of donated blood and blood products[100] namely, the performance of minimum tests on each donation, for infectious agents which may cause transfusion transmissible diseases such as syphilis, hepatitis B surface antigen (HBsAg), antibodies to the hepatitis C virus (anti-HCV), antibodies to the human immunodeficiency virus type 1 and 2 (anti-HIV 1 and 2), and p24 HIV1 antigen.[101] Mandatory requirement of red cell serology, including ABO grouping, Rh grouping,[102] and allo-agglutinin titre.[103] The blood transfusion service must periodically evaluate the latest scientific information pertaining to mandatory tests[104] based on scientific evidence and submit such information to the Minister of Health for

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89 S 64(2) of National Health Act 61 of 2003.
90 S 25(a) of Regulations.
91 S 25(b) of Regulations.
92 S 25(c) of Regulations.
93 S 25(d) of Regulations.
94 S 2 of Regulations.
95 S 3 of Regulations.
96 S 4 of Regulations.
97 S 5 of Regulations.
98 S 7 of Regulations.
99 S 8 of Regulations.
100 S 9 of Regulations.
101 S 9(1) (a) of Regulations.
102 S 9(1)(b) of Regulations.
103 S 9(1)(c) of Regulations.
104 S 9(2)(a) of Regulations.

appropriate action where necessary. Except for an autologous donation, no blood must be released for transfusion purposes if there is any reason to suspect from the donor's laboratory test results, medical history, past donation record or physical condition, that suggests that his or her blood may transmit disease.

It is mandatory with the requisition of blood and blood products, for a prescription in writing[105] and signed[106] by medical practitioner on a form created by the blood transfusion service and the blood sample should be taken from the recipient for compatibility testing,[107] with correct identification of the patient.[108] It also sets out the policies that should be in place for the institutions for the correct identification of the recipient of blood and blood products[109] and accurate permanent records of all the administered blood or blood products and documentation of adverse reactions.[110] The responsible person administering the blood or blood products must correctly identify the recipient of the blood or blood products.[111] Should there be an adverse reaction or death, the blood transfusion service is mandated to report to the Director-General of the Department of Health.[112] The blood transfusion service is mandated to record blood donors, blood donations, blood containers, statistics and untoward reactions.[113]

2.2.2 Guidelines of the South African National Blood transfusion Services

Based on the legislative requirements, the Western Cape Blood Transfusion Service and South African National Blood Transfusion Services, outlines the responsibilities of healthcare professionals for patient blood management. These duties include administering blood only when medically necessary, informing patients of associated risks and discussing alternative options. They must secure and document an informed consent, verify patient identity, specify the units of blood required and conduct compatibility testing. Additionally, healthcare professionals should ensure blood is appropriately handled before and during transfusions, remains within the expiry date and administered by qualified personnel. Proper transfusion practices include controlling the transfusions rate, closely monitoring the patient at the start

105 S 10(1)(a) of Regulations.
106 S 10(1)(b) of Regulations.
107 S 10(1)(b)(i) of Regulations.
108 S 10(1)(b)(ii) of Regulations.
109 S 10(2)(a) of Regulations.
110 S 10(2)(b) of Regulations.
111 S 10(3) of Regulations.
112 S 10(4) of Regulations.
113 S 12 of Regulations.

and throughout the process, promptly addressing any adverse reactions, retaining blood samples when needed and reporting any unexpected reactions or fatalities.[114]

Legal liability would therefore arise should these requirements not be met and if appropriate protocols are not followed. These areas fall outside the scope of this mini-dissertation. The next section pertaining to blood transfusions will be discussed in the context of informed consent, children's rights and best interests.

2.3 Informed Consent

Prior to the commencement of any medical treatment, a healthcare professional is mandated to obtain an informed consent, except in circumstances of a medical emergency where the life or health needs to be preserved. This consent may be expressed or implied and can be withdrawn at any stage and 'vitiated by any change in circumstances which are not communicated to and approved by the individual consenting'.[115] For consent to be considered valid and informed, there must adequate information disclosure, where the patient or consenting party must show competence and capacity to understand the information provided, there must be voluntary decision making, there must be adequate comprehension of the information disclosed, and consent must be provided for the proposed treatment or procedure.[116] Therefore, the onus is on the healthcare professional to communicate with a patient in a manner that is sensitive, taking cognisance of the patient's ability to comprehend the information provided to consent to treatment alongside the patient's maturity, level of education, intelligence and belief system.[117] This was clearly demonstrated in *Canterbury v Spence*[118] where it was said:

> The patient's right to self-determination can be effectively exercised only if the patient possesses enough information to enable intelligent choice ... True consent to what happens to oneself is the informed exercise of choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.

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114 Clinical guidelines for the use of blood products in South Africa, SANBS, 2023, 6th Edition.

115 S C Chima 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) 14 *BMC Medical Ethics* 1.

116 T L Beauchamp, R R Faden 'Informed consent: II. Meaning and elements of informed consent' in *Encyclopaedia of Bioethics* (1995) Vol 3:1240-1245.

117 Council for International Organizations of Medical Sciences (CIOMS) *International ethical guidelines for biomedical research involving human subjects* (1993).

118 *Canterbury v Spence* (1972) 464 2d 772 (DC).

Informed consent is considered as an ethical and legal doctrine derived from the principle of respect for autonomy and human rights where human beings are born free with equal dignity and rights endowed with reason and conscience 'enabling actions towards another in a spirit of brotherhood'.[119] This has been demonstrated in South African case law in *Minister of Safety and Security v Xaba*[120] where the Court refused the request for the removal of a bullet surgically from the accused so that it could be used as evidence. This violated the defendant's constitutional rights of bodily and psychological integrity, including the right to security and control of one's body.

Every competent adult possesses the right to consent or refuse medical treatment even if the consequences of decisions results in death.[121] This right to autonomy has found expression in numerous national and international statutes and codes of ethics. The right to autonomy alone is not regarded as a legally enforceable right but rather two rights derived from the principle of respect for autonomy which encompasses the right to bodily integrity which is a legally protected right against assault or battery and the right to be bodily integrity which is protected by professional negligence rules.[122] This concept was highlighted as legal concept in the judgement in *Schloendorf v Society of New York Hospital* where it was said:

> every human being of adult years and sound mind has a right to determine what shall be done with his own body, and the surgeon who performs and operation without his patients' consent commits an assault for which he is liable in damages.[123]

Informed consent operates 'within the framework of *volenti non fit injuria* or voluntary assumption of risk rather than delict'.[124] For consent to operate as a legal defence to criminal or civil liability, it must be recognised by law and not be *contra bonos mores*, it must be given by a person capable of consenting, it must be given free and voluntary without fear, coercion or fraud where the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk, appreciated and understood the harm or risk, and must have consented to the harm or assumed the risk. The consent must be comprehensive and extend to the entire transaction inclusive of the consequences. Consent must be 'unequivocal' and

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119 United Nations (UN) Universal Declaration of Human Rights United Nations, 1948.
120 *Minister of Safety and Security v Xaba* 2003 (2) SA 703 (D).
121 *Airedale NHS Trust v Bland* (1993) 2 WLR 316.
122 S C Chima 'Respect for autonomy as a prima facie right: Overriding patient autonomy in medical practice. Transactions' (2009) 53 *Journal of the Colleges of Medicine of South Africa (CMSA)*, 38.
123 *Schloendorf v Society of New York Hospital* (1914) 211 NY, 105 NE 92.
124 P Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) 877.

precede the conduct in question which must be inclusive of the limits of the consent given and must qualify as a 'juristic act'.[125]

2.3.1 National Health Act 61 of 2003

The NHA stipulates that health services may not be provided to a user without the informed consent,[126] where the healthcare professional must take all reasonable steps[127] to obtain an informed consent from a person with legal capacity,[128] unless the user is unable to give an informed consent and such consent is given by a person mandated by the user in writing to grant consent on his or her behalf or authorised to give such consent in terms of any law or Court order. Should the user be unable to give informed consent and no person is mandated or authorised to give such consent, the consent can be given by the proxy decision maker. The provision of a health service without an informed consent is authorised in terms of any law or a Court order where failure to treat the user or group of people which includes the user, will result in a serious risk to public health, or any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health where the user has not expressly, implied or by conduct refused that service.[129] Healthcare professionals are mandated to take into consideration the user's literacy level and comprehension[130] and inform the user of their health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user.[131] It is imperative that the range of diagnostic procedures and treatment options be generally available to the user,[132] that the benefits, risks, costs and consequences generally associated with each option are discussed prior to any decisions that are made.[133] The user has the right to refuse health services provided the implications, risks, obligations of such refusal have been explained.[134] A user has the right to participate in any decision affecting his or her personal health and treatment.[135]

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125 F F W Oosten *Doctrine of informed consent in Medical Law* (LLD Thesis, University of South Africa, 1989) 11.
126 S 7(1) of National Health Act 61 of 2003.
127 S 7(2) of National Health Act 61 of 2003.
128 S 7(3) of National health Act 61 of 2003.
129 S 6(1)(a-e) of National Health Act 61 of 2003.
130 S 6(2) of National Health Act 61 of 2003.
131 S 7(1)(a) of National Health Act 61 of 2003.
132 S 7(1)(b) of National Health Act 61 of 2003.
133 S 7(1)(c) of National Health Act 61 of 2003.
134 S 7(1)(d) of National Health Act 61 of 2003.
135 S 8 of National Health Act 61 of 2003.

2.3.2 Common Law

Patient consent is mandatory in all medical interventions. The South African courts earliest case was that of *Stoffberg v Elliot*,[136] where the doctors were sued for damages in action for assault when a patient had an amputation of his penis without an informed consent. The judge in this case opined:

> In the eyes of the law, every person has certain absolute rights, which the law protects. They are not dependent upon a statute or upon a contract, but they are rights to be respected, and one of those rights is the right of absolute security of the person … Any bodily interference with restraint of a man's person which is not justified in law or excused by law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference.

The case of *Esterhuizen v Administrator Transvaal*,[137] concerned a child of ten years, diagnosed as having Kaposi's sarcoma, where the parents consented to superficial radiation therapy. The patient relapsed and required aggressive radiation therapy that resulted in complications with severe radiation burns that necessitated amputation. In this case, it was ruled that subsequent treatment was performed without prior informed consent and the implied consent that was used as defence, was found to be inadequate and could not be used as defence based on previous treatment performed on the child. This was despite the argument put forward by the defence that the treatment was performed in the child's best interests because treatment was 'vastly different' from the initial treatment where superficial radiation was given.

The *Castell v De Greef* case serves as a landmark case that 'consolidated the doctrine of informed consent' into South Africa law. This case demonstrated a shift from medical paternalism to patient autonomy and shift from the 'reasonable doctor' standard to the 'prudent patient' standard. It signified a shift in disclosure to the 'material risk' standard, where the level of disclosure required is what a reasonable patient would consider pertinent prior to decision-making. The Court held that a medical practitioner has a duty to warn a patient of a material risk associated with a procedure, whereby risk is regarded as material where a reasonable person in the position of the patient, if so warned of the risk, would be likely to attach significance to it, or the medical practitioner is or should reasonably be aware that the

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136 *Stoffberg v Elliot* (1923) CPD 148-150.
137 *Esterhuizen v Administrator Transvaal* (1957) (3) SA 710 (T).

patient, if warned, would be likely to attach significance to it. The Court held that for consent to be used as a defence:

> the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk; the consenting party must have appreciated and understood the nature and extent of the harm or risk; the consenting party must have consented to the harm or assumed the risk; the consent must be comprehensive, that it extends to the entire transaction, inclusive of its consequences.[138]

The case of *McDonald v Wroe*[139] the Court ruled against a dentist who performed an extraction of an infected wisdom tooth without the prerequisite informed consent prior to surgery and failing to inform the patient of the material risks. The Court held that this amounted to a violation of the patient's right to bodily integrity based on section 12(2) of the Constitution.

In the case of *Sibisi NO v Maitin*,[140] the Supreme Court of appeal dealt with the meaning of informed consent to medical treatment where the patient must be 'made aware of the risks of the procedure in order to make an informed decision'. The case involved Dr Maitin who was sued for the injuries sustained to the child during delivery by performance of the McRoberts manoeuvre and the failure of adequate informed consent. The court was called,

> to extend common law, so as to recognise that the test for whether the patient has given informed consent to a procedure, should be whether the reasonable patient in the position of the plaintiff would regard the risk as significant and elect not to undergo the procedure or follow a different mode of treatment. The test would recognise the patient's right to autonomy and bodily integrity.

Although the case was dismissed as no negligence could be established, the Court applied the principles of informed consent as established in *Castell v De Greef*, where the reasonable person in the position of the patient would choose a lesser invasive procedure had the patient known the risks.

The recently reported judgement in *Beukes v Smith*[141] reaffirmed this doctrine. In the aforementioned case, the patient Ms Beukes had sustained a colonic perforation during a laparoscopic procedure and sued the doctor based on the argument that she was not adequately

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138 *Castell v De Greef* 1994 (4) SA 408 (C).
139 *McDonald v Wroe* (2006) (3) All SA 565 (C).
140 *Sibisi v Maitin* (2014) (6) SA 553 (SCA).
141 *Beukes v Smith* 2020 (4) SA 51(SCA).

informed of the procedure risks and not provided with alternatives to her treatment. The judge opined that:

> Courts employ a patient-based approach. The reasoning is that the patient's freedom to self-determination includes the right to decide whether she wants to undergo surgery. A patient is entitled to refuse medical treatment. If she consents to surgery or medical treatment, she accepts responsibility for unintended harm in the medical treatment, in the in the principle of *volenti non fit injuria*.

Legal consequences of inadequate and absent informed consent would result in liability on grounds of breach of contract, civil or criminal assault resulting from a violation of bodily integrity, civil or criminal injuria consequential to a violation of *dignitas* or privacy and negligence.[142] In the case of *C v Minister of Correctional Services,*[143] the court ruled that although the prisoner consented to have blood tests performed, he did not consent to a blood test for HIV, and that the conduct of the prison officer to request a test for HIV constituted an invasion of privacy and guilty of assault. Further, it is suggested that the negligent conduct of healthcare professional's failure to obtain an informed consent would constitute assault, irrespective of their intentions. Moreover, performance of any procedure that is contrary to the statutory provisions and *contra bonos mores* would constitute assault, inclusive of any individual that may be complicit in assisting in performance of such treatment or procedure.[144]

2.4 Best interest standards and children

The concept of best interests of the child was introduced as a common law rule in South Africa in *Fletcher v Fletcher.*[145] Although the matter related to the validity of a trust and the beneficiaries, the case established principles of protecting children's future wellbeing, where the beneficiaries were children. The court ruled that the most important factor that the courts should consider in decision making in a child, is the best interests of the child rather than the parents. This was regarded as a 'golden thread' by the courts for the law pertaining to children as stated in the custody case of *Kaiser v Chamber.*[146] The best interests of the child for a particular case would depend on individual circumstances that should be determined

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142 F Van Oosten, 'The Law and Ethics of Information and Consent in Medical Research' (2000) 63 *THRHR* 5-31.
143 *C v Minister of Correctional Services* 1996 (4) SA 292 (T).
144 M A Dada & D McQuoid-Mason *Introduction to Medico-Legal Practice* (2001) 9; 29.
145 *Fletcher v Fletcher* 1948 (1) SA 130(A) 143.
146 *Kaiser v Chamber* 1969 (4) SA 224 (C) 228 F.

individually on merit.[147] The South African Constitution[148] makes provision for the South African government to consider international and human rights laws and obliges the state to take the necessary legislative measures. Consequently, as signatories of the CRC and the African Rights Charter, it obliges the South African government to implement the necessary measures, which are inherent in the Constitution, NHA, Children's Act and Choice of Termination of Pregnancy Act[149] (here after referred to as Choice Act).

2.5 Realisation of children's rights and consent provisions

The quest for the rights of children has its origins in the Geneva Declaration which recognised the existence of rights specific to children and the responsibility of adults towards children.[150] The subsequent Declaration of the Rights of the Child[151] and Convention on the Rights of the Child,[152] and African Rights Charter,[153] informed policy decisions and reinforced the rights of the child.

2.5.1 Constitution of the Republic of South Africa, 1996

The founding principles of the South African Constitution is regarded as the most progressive and admirable constitutions in the world and is founded on the values of human dignity, equality and the advancement of human dignity, the achievement of equality and the advancement of rights and freedoms,[154] where the supremacy of the Constitution and rule of law applies,[155] and places an obligation on the State to ensure and enforce any conduct that is inconsistent with the law.[156]

Section 28 of the Constitution[157] guarantees the rights of children, where a child is regarded as a person less than eighteen years of age.[158] Children's best interests are of 'paramount

147 S Ferreira 'The best interest of the child: From complete indeterminacy to guidance by the Children's Act' (2010) 73 *THHR* 201.
148 S 39(1)(b) of The Constitution of the Republic of South Africa, 1996.
149 The Choice on Termination of Pregnancy Act 92 of 1996.
150 Geneva declaration of the rights of the Child, 1924.
151 Declaration of the Rights of the Child adopted by the UN general assembly Resolution1386 (XIV) of 10th December 1959.
152 Convention on the Rights of the Child Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49.
153 African Rights Charter on the Rights and Welfare of the Child 29 November 1999.
154 S 1(a) of The Constitution of the Republic of South Africa, 1996.
155 S 1(c) of The Constitution of the Republic of South Africa, 1996.
156 S 2 of The Constitution of the Republic of South Africa, 1996.
157 S 28 of The Constitution of the Republic of South Africa, 1996.
158 S 28(3) of The Constitution of the Republic of South Africa, 1996.

importance' in every matter concerning the child.[159] The Constitution provides for the right for any persons belonging to a religious or cultural community to practice their religion,[160] to form, join and maintain religious associations,[161] provided these rights are not exercised in a manner contrary to the Bill of Rights.[162] Section 27 recognises the right to access healthcare services emphasising the importance of consent in medical and reproductive decisions.

The rights to autonomy are derived from the combination of the rights to privacy, freedom of religion, freedom of expression and freedom of association.[163] The rights to privacy have been interpreted by the courts to encompass the principle of autonomy as ruled by The Constitutional Court in *Case & Curtis v Minister of Security*, where the Court ruled on the extension on the right to privacy to 'substantive or personal autonomy rights'. This interpretation allows for decision-making for people in the private sphere of their lives inclusive of their families, home and sexual lives without interference including the state.[164] It is also submitted that human dignity, is regarded as the 'anchor norm' and 'underscores' the doctrine of informed consent in order to make autonomous decisions.[165]

Children have similar rights to adults that are further reinforced by the Bill of Rights.[166] The Bill of Rights explicitly ensures that everyone has the right to equality and equal protection and benefit before the law without being discriminated against on listed grounds of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief culture, language and birth.[167] The Bill of Rights also protects the rights of every person including children, the right to human dignity and to have their right to human dignity respected and protected,[168] the rights of bodily and psychological integrity

159 S 28(2) of The Constitution of the Republic of South Africa, 1996.
160 S 31(1)(a) of The Constitution of the Republic of South Africa, 1996.
161 S 31(1)(b) of The Constitution of the Republic of South Africa, 1996.
162 S 31(2) of The Constitution of the Republic of South Africa, 1996.
163 B Bekin, D Brand 'Constitutional Protection in Children' in C J Davel (ed) et al Introduction to child law in South Africa (2000) 178 in H Kruger 'The Protection of Children's Right to Self-Determination in South African Law with Specific Reference to Medical Treatment and Operations' (2018) 21 *PELJ* 18.
164 *Case & Curtis v Minister of Security* 1996 (3) SA 617(CC).
165 M Swart & P Carstens 'The application of the doctrine of informed consent in South African medical law: Reflections on significant developments in case law' 2024 *SALJ*, 53.
166 Chapter 2 of The Constitution of the Republic of South Africa, 1996.
167 S 9 of The Constitution of the Republic of South Africa, 1996.
168 S 10 of The Constitution of the Republic of South Africa, 1996.

which are inclusive of the right to make decisions concerning reproduction,[169] and protection toward every person's right to security and control over their body.[170]

2.5.2 Children's Act 38 of 2005

Important founding principles of the Children's Act are that all decisions in matters concerning the child must respect, protect, promote and fulfil the child's rights as set out in the Bill of Rights, the best interests of the child,[171] and must protect the child's inherent dignity, treating the child fairly and equitably while protecting against unfair discrimination, taking into consideration and recognising the child's need for development and disability.[172] The child's best interests should be taken into consideration in conjunction with the views expressed by the family.[173] Consideration should be given to the child's age, maturity and stage of development in any matter concerning the child.[174] The child's best interests should be considered at all times,[175] where the child's best interests is of 'paramount importance'.[176] Every child:

> of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way and views expressed by the child must be given due consideration.[177]

The Children's Act also stipulates that every child has the right not to be subjected to social, cultural and religious practices which are considered detrimental to the child's wellbeing.[178] Every child has the right to access to information that is relevant and in a format that is accessible to children[179] in respect of their health status, promotion of sexual and reproductive health.[180]

Section 129 of the Children's Act sets out the criteria for the consent to medical and surgical treatment of children over twelve years of age. It also stipulates the criteria should the child be

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169 S 12(2)(a) of The Constitution of the Republic of South Africa, 1996.
170 S 12(2)(b) of The Constitution of the Republic of South Africa, 1996.
171 S 7 of Children's Act 38 of 2005.
172 S 2(a)-(e) of Children's Act 38 of 2005.
173 S 3 of Children's Act 38 of 2005.
174 S 5 of Children's Act 38 of 2005.
175 S 7 of Children's Act 38 of 2005.
176 S 9 of Children's Act 38 of 2005.
177 S 10 of Children's Act 38 of 2005.
178 S 12 of Children's Act 38 of 2005.
179 S 13(2) of Children's Act 38 of 2005.
180 S 13(1)(a)-(c) of Children's Act 38 of 2005.

under the age of twelve years or above the age of twelve and does not meet the maturity requirements.[181] A child may consent to his or her own medical treatment if the child is above the age of twelve years[182] and the child has sufficient maturity and the mental capacity to understand the benefits, risks, social and other implications of the treatment.[183] The child above the age of twelve years may also consent to surgery[184] if the child has sufficient maturity and mental capacity to understand the benefits, risk, and social implications of the surgical operation.[185] The child should duly be assisted by the parent or guardian.[186]

A parent, guardian or care giver can provide consent to medical treatment[187] or surgery[188] on behalf of the child if under the age of twelve years or above the age and has insufficient maturity and mental capacity to understand the benefits, risk, and social implications of the medical treatment or surgical operation. The Children's Act does not define medical treatment or surgery or operation. Neither does it stipulate as to what constitutes sufficient maturity. This is significant noting the implications for consent.

Alternative decision makers for medical or surgical treatment are also stipulated in the case of emergency where the treatment of the minor cannot be delayed and is essential to preserve or save the life of the minor.[189] Should the parents or guardian refuse treatment or assisting the child cannot be traced, then it becomes incumbent on the Minister to provide consent.[190] The Minister may also provide consent where a child unreasonably refuses to give consent.[191] Moreover, the High Court's judgement of *Hay v B*,[192] highlights the rights of children to emergency medical treatment. This case involved the parental refusal of blood transfusions based on religious beliefs and concerns of infection and the application by a paediatrician to the High Court on the basis of medical emergency to preserve the life of the child. The case was significant in that while it recognised the parent's rights to religious beliefs, the child's best interests and constitutional rights were paramount. The Court ordered for the administration of a blood transfusion. The judgement predated the Children's Act, which was

181 S 129(2) of Children's Act 38 of 2005.
182 S 129(2)(a) of Children's Act 38 of 2005.
183 S 129(2)(b) of Children's Act 38 of 2005.
184 S 129(3)(a) of Children's Act 38 of 2005.
185 S 129 (3)(b) of Children's Act 38 of 2005.
186 S 129(3)(c) of Children's Act 38 of 2005.
187 S 129 (4)(a-b) of Children's Act 38 of 2005.
188 S 129 (5)(a-b) of Children's Act 38 of 2005.
189 S 129 (6)(a-c) of Children's Act 38 of 2005.
190 S 129 (7)(a-d) of Children's Act 38 of 2005.
191 S 129 (85) of Children's Act 38 of 2005.
192 *Hay v B* 2003 (3) SA 494 (W).

subsequently enacted with provisions as stipulated in section 129 (10), which states that no parent, guardian or caregiver can refuse or withhold consent on grounds of religious and/or other beliefs unless they can show a medically acceptable alternative to the medical or surgical operation concerned.[193]

2.5.3 Choice on Termination of Pregnancy Act 92 of 1996

With regards to the Choice Act, termination of pregnancy may only take place with an informed consent where a pregnant female of any age can consent to termination of pregnancy.[194] No other consent would be required other than that of a pregnant woman.[195] It remains essential that the healthcare professional, whether a doctor or midwife, advise a pregnant minor that she may consult with her parents, guardian, family members or friends before the termination of her pregnancy. However, the termination may not be denied because she chooses not to consult them.[196] There is an obligation on the State to promote the provision of 'nonmandatory and non-directive counselling' before and after the termination of a pregnancy.[197] The right to self-determination was highlighted in *Christian Lawyers' Association v National Minister of Health 2005*,[198] and emphasised the rights afforded to everyone based on the Constitution and Bill of Rights to inherent dignity and the right to have their dignity respected and protected, the right to bodily and psychological integrity, including the right to security and control over their body, and the right to privacy and the right to reproductive healthcare. The ruling was significant in the context of the termination of pregnancy and minors. The Court ruled that that limitation of these fundamental rights was valid in terms of section 36(1) of the Constitution, where the justification of the rights would be considered as rational. The Court further held that the distinction between the women who were capable of giving informed consent and those who were not confers a rational distinction.

193 S 129(10) of Children's Act 38 of 2005.
194 The Choice on Termination of Pregnancy Act 92 of 1996.
195 S 5(2) of Choice on Termination of Pregnancy Act 92 of 1996.
196 S 5(3) of Choice on Termination of Pregnancy Act 92 of 1996.
197 S 4 of Choice on Termination of Pregnancy Act 92 of 1996.
198 *Christian Lawyers' Association v National Minister of Health* 2005 (1) SA 509 (T) at 515A-B.

2.5.4 International Human Rights instruments

2.5.4.1 Convention on the Rights of the Child

The CRC recognised the fundamental human rights of 'inherent dignity' and 'inalienable rights' of all members of the human family without any discrimination. It recognised that children are entitled to 'special care and assistance' where the child's growth is encouraged in a family environment that promotes 'harmonious development' in their personality so that the child can be integrated into society in the 'spirit of peace, dignity, tolerance freedom, equality and solidarity' with the necessary protection to assume its responsibilities.[199]

The rights in the CRC are often 'classified as the four "Ps", namely, the provision rights, protection rights, prevention rights and participation rights'.[200] Stipulated in the CRC is for State parties to respect and ensure the children's rights and to take all appropriate measures to ensure that the rights of children are protected against all forms of discrimination or punishment on the basis of status, activities, and the expressed opinions or beliefs of the child's parents, legal guardians or family members.[201] The best interests of the child should be regarded as 'a primary consideration' in all action concerning children, irrespective if this is undertaken by private or public institutions, courts or any administrative or legislative bodies.[202] Every child has an inherent right to life and this should be protected and promoted to the 'maximal extent'.[203] The CRC recognises the responsibilities and rights and duties of parents, members of extended family or community as provided for by local custom, and/or legal guardians, to provide direction and guidance in a manner recognising the evolving capacity of the child.[204]

The CRC states that where a child is capable of forming his or own views, the child should be afforded the opportunity to express those views taking cognisance of the age and maturity of the child.[205] This freedom of expression, whether orally or in writing,[206] through any medium, would be subject to restrictions as stipulated by law for the protection of national security, public order, public health or morals.[207] The CRC further recognises the right of the child to

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199 Preamble - Convention on the Rights of the Child (CRC) adopted 20 November 1989.
200 T Hammarberg 'The UN Convention on Rights of the Child-and how to make it work' (1990) 12 *The Human Rights Quarterly* 100.
201 Article 2 of CRC.
202 Article 3 of CRC.
203 Article 6 of CRC.
204 Article 5 of CRC.
205 Article 12 of CRC.
206 Article 13(1) of CRC.
207 Article 13(2) of CRC.

freedom of thought and religion to be enforced by the State parties, which should also respect the rights of parents or legal guardians, to provide direction to the child in exercise of the child's rights, taking into consideration the child's evolving capacities. This is subject to limitations as prescribed by law to protect public safety, order, health or morals or protection of fundamental rights of others.[208]

Therefore, the stipulations of the CRC are significant for establishing the rights of the child and decision-making. Parental rights and beliefs are recognised taking cognisance of the age, evolving capacity and maturity of the child. This is significant for the consent provisions of children especially in the context of best interest standards and religious beliefs.

2.5.4.2 African Charter on the Rights and Welfare of Children

In response to concerns that the CRC failed to address certain 'unique factors' specific to the African continent, the African Charter was adopted by the Organization of African Unity, taking into consideration the 'virtues of their cultural heritage, historical background and values of the African civilization'.[209] The signatories of the African Charter undertook to take all the necessary legislative measures in accordance with their constitutional processes to effect any provisions of the African Charter to promote the rights and welfare of the child.[210] Corresponding with CRC, the African Charter recognised the inherent right to life and development of the child,[211] including the best interests of the child, where the best interests of the child is 'the primary consideration',[212] who is capable of communicating their views to be heard and to be taken into consideration by relevant authorities.[213] The African Charter reinforced the rights of non-discrimination and freedoms of the child[214] such as, the right to freedom of expression where 'every child who is capable of communicating his or own views freely in all matters',[215] the right to freedom of thought, conscience and religion and the duty of parents or legal guardians to provide guidance and direction to exercise these rights. All of

208 Article 14 of CRC.
209 Preamble of the African Rights Charter on the Rights and Welfare of the Child 29 November 1999.
210 Article 1 African Charter.
211 Article 5 of African Charter.
212 Article 4 of African Charter.
213 Article 7 of African Charter.
214 Article 3 of African Charter.
215 Article 7 of African Charter.

which take into consideration the evolving capacity and best interests of the child providing that this in not contrary to national laws and policies which must be reinforced by the state.[216]

2.6 The concept of 'paramount' versus 'primary' in best interests

With regards to best interests of the child, the Children's Act sets out a list of fourteen factors that should be taken into consideration.[217] Conversely, this is not regarded as an 'open ended' list as determined in the ruling in the landmark case of *McCall v McCall* 'where any other factor which is relevant to the particular case with which the court is concerned'.[218] The case involved a dispute between divorced parents over custody of their minor child and related to the custody arrangement that would best serve the interest of the child taking into consideration the child's wellbeing, stability and overall development. The Court established a set of criteria to assist the courts in the best interests of the child in custody disputes. The case highlighted that courts should apply discretion in considering other factors that are relevant because lists on best interest standards can never be complete for every scenario.[219]

The different phraseology applied in the Constitution, CRC and African Charter is interesting and significant in its interpretation. While the use of 'primary consideration' is in both the CRC and African Charter, the Constitution states that a child's best interests remain paramount. It is submitted that the use of 'the primary consideration' in the African Charter as opposed to 'a primary consideration' in the CRC confers greater protection of the child's best interests by the African Charter than the CRC. This is because its wording provides greater flexibility to accommodate competing interests other than the children to prevail. The wording in the Constitution of child's best interests being of 'paramount importance' is considered as 'emphatic' and more significant.[220]

In *S v M*,[221] the Constitutional Court held that because the child's best interests are paramount, these rights are not absolute and is subject to limitations as it remains imperative to take into consideration the facts of each individual case when making decisions in the best interests of the child. The Court further ruled that if this principle:

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216 Article 9 of African Charter.
217 S7 of Children's Act 38 of 2005.
218 *McCall v McCall* 1994 (3) SA 201 (C).
219 S Ferreira 'The best interest of the child: From complete indeterminacy to guidance by the Children's Act' (2010) 73 *THHR* 212.
220 Ibid at 205.
221 *S v M 2007* (12) BCLR (CC); 2008 (3) SA 232(CC.).

> is spread too thin it risks being transformed from an effective instrument of child protection into an empty rhetorical phrase of weak application, thereby defeating rather than promoting its objective.

The case involved a mother, *M,* who was convicted of fraud and sentenced to four years of imprisonment. The mother was also the primary care giver of three young children. The court ruled that the sentencing Court had failed to consider the best interests of the child and referred the matter back to the Trial Court for reconsideration. This view was also reaffirmed by the Constitutional Court where it was held that section 28(2) of the Constitution is subject to limitations in *Minister of Welfare and Population Development v Fitzpatric,*[222] where foreign nationals applied to adopt a South African child. The Constitutional Court held that provisions of the Child Care Act unfairly discriminated against non-citizens and violated the best interests of the child which remains of paramount importance in matters of the child and that the best interest standards should be flexible depending on the individual circumstance. This was reaffirmed in the case of *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division*,[223] where *De Reuck* was charged in possession of child pornography and challenged the Court on the basis that this infringed in his Constitutional rights to freedom of expression and privacy. The Constitutional Court held that these rights were subject to limitations in an open and democratic society in order protect the best interests of children. This case was significant as it established the parameters within which rights can be limited in order to protect children.

2.7 Conclusion

The administration of a blood transfusion is commensurate with a sequence of events that catalyses a 'transfusion chain'[224] from donation to administration of blood to the recipient. Compliance with regulatory requirements with regards to the management of blood and blood products, includes the mandatory processing and testing of blood and blood products for appropriate indication for administration identified by the healthcare professional.

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222 *Minister of Welfare and Population Development v Fitzpatric* 2000 (3) 2000.

223 *De Reuck v Director of Public Prosecutions, Witwatersrand Local Division* 2004 (1) SA 406 (CC).

224 J Orkuma & O Ayia 'Ethico-legal aspects of hospital-based blood transfusion practice: implications of professional negligence to medical practitioners: A Review' (2014) 3(3) *International Journal of Medicine and Biomedical Research* 219-235.

A crucial and mandatory aspect of the doctor-patient relationship is the provision of an informed consent prior to any treatment, procedure or surgery envisaged. The current shift of paradigm is from the 'reasonable doctor standard' and 'medical paternalism' to the self-determination and autonomy of patients. It is noted that 'successful interplay between human rights and rules of medical ethics is crucial in providing adequate healthcare services'.[225] This by implication would entail that 'autonomy implies responsibility' and taking responsibility for decision making the context of healthcare.[226]

The right to autonomy is further elucidated in *Castell v De Greef,*[227] where the Full Bench of the Cape Provincial Division of the Supreme Court of South Africa stated that,

> It is clearly for the patient, in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo an operation, and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment.

The respect for patient's autonomy behoves the healthcare professional in always being truthful, respecting the privacy of others, protecting confidentiality, obtaining the patient's consent prior to any medical intervention and providing the necessary assistance for decision making.[228] This has been further reinforced by the Health Professional Council of South Africa Guidelines for Good Clinical Practice, which requires physicians to respect the patient's right to self-determination in its definition of autonomy.[229] The multiple judgements in South African case law, have confirmed the principle of patient autonomy are significant in the context of both adults and children. They collectively reinforce the doctrine of informed consent which entails having knowledge and appreciation.

The constitutional right to bodily and psychological integrity and the right to security in control over the body confers the right to consent and the corresponding right to refusal of treatment.[230] This right has been reaffirmed by the National Health Act, which requires the healthcare

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225 A Dhai & D McQuoid-Mason *Bioethics, Human Rights and Health Law: Principles in Practice in Health Law* 2nd ed (2020) 96.

226 International Bioethics Committee (IBC) *Report of the International Bioethics Committee of UNESCO on Consent. Social and Human Sciences Sector* Division of Ethics of Science and Technology, Bioethics Section SHS/EST/CIB08-09/2008/1, UNESCO 2008.

227 *Castell v De Greef* 1994 (4) SA 408 (C).

228 T L Beauchamp and J F Childress *Principles of Biomedical Ethics* 8th ed (2019) 231.

229 Guidelines on Good Clinical Practice in Healthcare Profession, Booklet 1 para 2.3.5.

230 S 12(2)(b) of The Constitution of the Republic of South Africa, 1996.

professional to inform patients of the right to refuse health services and explain the risks and obligations of such refusal.[231] This is provided that the patient has the legal capacity to consent, or in the absence of legal capacity, the doctrine of necessity where treatment cannot be delayed in order to preserve a life. The autonomy of children with evolving capacity and consenting age does not necessarily apply if this is in contradiction to the best interests of the child.

The next chapter explores blood transfusions, and the rights based on religious beliefs and the protection afforded to children in accordance with best interest standards.

[231] S 6(1)(d) of National Health Act 61 of 2003.

CHAPTER 3: COMPARATIVE LAW AND BLOOD TRANSFUSIONS

3.1 Introduction

The family union is key in the transmission of religious beliefs and religious culture to family members and children. A child is born without any choice on religion and the child's identity is conferred upon the child by the parents.[232] Various aspects of religion, education and discipline play a significant role in influencing parental decisions regarding the welfare of the household. Although parental authority has evolved over time, these rights are balanced by the constitutional principle of best interests of the child. The rights of parents are not absolute when parental authority and parenting may come into conflict with the best interests of the child, the state's autonomy rights, and medical paternalism. This chapter highlights the rights of adults to religious beliefs, and adults' rights to refuse treatment in the context of blood transfusions and Jehovah's Witnesses. The chapter will also focus on the best interests of children in the context of blood transfusions and the protection afforded to children. Chapter four will focus on the autonomy of children and decision-making capacity. This chapter considers the case law in various jurisdictions in the context of Jehovah's Witnesses and blood transfusions.

3.2 Constitutional rights to religious beliefs

The Constitution guarantees the freedom of religion, conscience, thoughts, and belief.[233] This is reinforced when read with section 31 of the Bill of Rights,[234] which protects the rights of a community to practice their religion and applies to all laws, whether statutory, common law or customary. Inherent to the Bill of Rights is that everyone is equal before the law with equal protection and benefit from the law, without discrimination either directly or indirectly, on the grounds of religion and age. Every person has the right to participate in the cultural life of their choosing in any manner that is consistent with the Bill of Rights.[235] Additionally, people belonging to a religious community have the right to associate with other members of such community and practice their religion.

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232 A Scolnicov 'The Child's right to Religious Freedom and Formation of Identity' (2007) 15 *International Journal of Children's Rights* 251-267.

233 S 15(1) of The Constitution of the Republic of South Africa, 1996.

234 S 31 Chapter 2 (Bill of Rights) of The Constitution of the Republic of South Africa, 1996.

235 S 30 Chapter 2 (Bill of Rights) of The Constitution of the Republic of South Africa, 1996.

This conforms to human rights instruments which have been influential in freedom of thought, conscience and religious rights and beliefs that have been included in the Universal Declaration of Human Rights,[236] International Covenant on Civil and Political Rights[237] and European Convention for the Protection of Human Rights and Fundamental Freedoms.[238] The South African Charter of Religious Rights and Freedoms outlines the promotion of religious freedoms in the South African context.[239] In addition to general rights afforded to everyone, children have also been conferred with additional rights to family and parental care, basic healthcare services and the right not to be subjected to maltreatment, neglect, abuse and degradation.[240] While the Bill of Rights does not indicate which right should take precedence, it is submitted that rights encompassing basic values of human dignity, equality and freedom would prevail over any other right as alluded to in *S v Makwanyane,* where the Constitutional Court determined that the 'right to life and dignity is the most important of all human rights'.[241]

3.3 Parental rights to influence religious upbringing

It is submitted that parent's constitutional right to freedom of religion includes their ability to guide their children's religious choices, while the scope of a child's freedom of religion is influenced by their level of maturity and the religious direction provided by the parents.[242]

The Constitution guarantees the rights of children to have parental care, family or appropriate level of care when removed from the family environment.[243] The freedom of religion, belief and opinion, confers the rights of parents the right to raise their children according to their religious beliefs.[244] The rights to equality and prohibition of discrimination inclusive of grounds of religion, enhances the child's right to be raised in an environment free from any religious coercion and allows the child to adopt their beliefs as they mature.[245] The Children's Act defines parental responsibilities for caring for the child, maintaining contact with the child, acting as a guardian and contributing to the child's maintenance. This responsibility also

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236 Article 17 of the Universal Declaration of Human Rights (1948).
237 Article 18(1) of the International Covenant on Civil and Political Rights (1966).
238 Article 9(1) of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950).
239 The South African Charter of Religious Rights and Freedoms (1990).
240 S 28(a)-(i) of The Constitution of the Republic of South Africa, 1996.
241 *S v Makwanyane* 1995 (3) SA 391 (CC).
242 S de Freitas 'Freedom to agreed-upon religious upbringing of the child on dissolution of a marriage: A critique of Kotze v Kotze' (2021) 54 *De Jure Law Journal* 533-548.
243 S (28) of The Constitution of the Republic of South Africa, 1996.
244 S (15) of The Constitution of the Republic of South Africa, 1996.
245 S (9) of The Constitution of the Republic of South Africa, 1996.

encompasses influencing and guiding the child's upbringing, inclusive of religion.[246] Once the child is capable of formulating an opinion,[247] the parents must consider the child's religious upbringing by considering the wishes of the child, noting the child's age, maturity, and stage of development prior to any decision making inclusive of the religious upbringing.[248] The Constitution and the Children's Act places the best interests of the child being of paramount importance. Parental power may be exercised equally by both parents and this centricity of the autonomy of parents and family, is recognised by international human rights instruments. Article 26(3) of the Universal Declaration of Human Rights, states that 'parents have a prior right to choose the kind of education that shall be given to their children'. Moreover, Article 18(4) of the International Covenant on Civil and Political Rights, (ICCPR), states to undertake to 'have respect for the liberty of parents and, when applicable legal guardian, to ensure the religious education as a right of the parents rather than the individual child'.[249] Similarly, Article 13(3) of the International Covenant on Economic Social and Cultural Rights mentions respect for the liberty of parents and where applicable legal guardians, to choose education and for states to ensure moral education of their children in conformity with their own convictions.[250] The CRC recognises that parents are the best persons to have common responsibilities to raise their children, where the best interests of the child is the basic concern, and for the state to provide appropriate assistance to facilitate the performance of their child rearing responsibilities.[251] Children's right to freedom of thought, conscience and religion is reinforced by Article 9 of the African Charter, which recognises the rights of parents and legal guardians and duties of the state to provide direction in the exercise of these rights, taking into consideration the evolving capacities and best interests of the child.[252] The Declaration on the Elimination of All Forms of Intolerance and Discrimination Based on Religion and Belief, recognises the rights to access education without being compelled against, in line with parental or guardian wishes, in the best interests of the child.[253] In the European Convention on Human Rights, the rights of parents are inferred through several articles within the Convention. Article 8 of the European Convention mentions that 'everyone has the right to respect for his private and family life, his home and his correspondence'. Protocol 1, Article 2 expounds on the right

246 S (18) of The Constitution of the Republic of South Africa, 1996.
247 S (11) of The Constitution of the Republic of South Africa, 1996.
248 S (31) of The Constitution of the Republic of South Africa, 1996.
249 Article 18(4) of ICCPR (1996).
250 Article 13(3) of International Covenant on Economic Social and Cultural Rights (1966).
251 Article 18(1) – (2) of CRC (1989).
252 Article 9 of the African Charter.
253 The Declaration on the Elimination of All Forms of Intolerance and Discrimination Based on Religion and Belief, Adopted 25 November 1981, General Assembly Resolution 36/55, United Nations.

to education and recognition of the right of parents to ensure such education in teaching with their 'own religious and philosophical convictions'.[254] Article 9 addresses the freedom of thought, conscience and religion. The United Kingdom which is also a signatory of the European Convention on Human Rights, addresses the responsibility of parents in the Children's Act, of having the right to religious upbringing inclusive of participation in religious activities and attendance at religious services.[255]

The right to religious education should take into consideration the constitutional rights and best interests of the child, as determined in *Allsop v McCann*,[256] where the courts had to determine responsibilities of divorced parents in making decisions about their children's religious upbringing. The court's approach was to encourage the parents to reach an agreement in the best interests of the child. This is further exemplified in the United States landmark case of *Wisconsin v Yoder* which highlighted the First Amendment's guarantee of religious freedom.[257] The case involved Amish families who refused to send their children to school beyond the eighth grade, after the age of fourteen. The parents argued that attendance in school was contrary to religious beliefs and freedom. The court ruled that the families right to freedom of religion outweighed the state's interest in the education of the children.

3.4 Limitation of religious rights

The right to practice one's religion is not absolute and may be subject to limitation by the Constitution and enforced by the courts. Consequently, this may be dealt with by the courts should there be doubt about the authenticity of the religious beliefs conforming to the religious doctrine of the particular religion being practiced. The courts require that, when a practice is prohibited, it must be established that the practice is indeed a fundamental aspect of the religious belief, particularly in cases involving refusal of blood transfusions. Additionally, if the religious practices conflict with other constitutional rights, such as the right to life or health, those practices may be restricted or excluded to uphold broader constitutional principles.[258] This is clearly elucidated by *Prince v President of Law Society of Good Hope*[259] which dealt with religious freedom and equality. The case involved a Rastafarian law student with two

254 European Convention on Human Rights (1950).
255 S (3) Children's Act 1989, c.41(UK).
256 *Allsop v McCann* 2000 (3) All SA 475 (C).
257 *Wisconsin v Yoder* 406 U.S. 205(1972).
258 B Bekink 'Parental religious freedom and the rights and best interest of children' 2003 *THRHR* 246-265.
259 *Prince v President of Law Society of Good Hope* 2002 (2) SA 794 (CC).

previous convictions for possession of cannabis who applied to be admitted as an attorney at the Law Society of the Cape of Good Hope. The Constitutional Court dismissed Prince's appeal on grounds that the prohibition of cannabis served as a legitimate and compelling government interest to protect public health, safety and order. Although cannabis usage has since been legalised, the principles established from the case are pertinent with respect to limitations based on religious beliefs.

In *Islamic Unity Convention v Independent Broadcasting Authority*,[260] a Muslim radio station challenged the broadcasting codes limitations on religious content, arguing that this infringed on their right to religious freedom. The Constitutional Court held that while the freedom of religion and expression is protected, the limitations in the broadcasting code were justifiable to protect the rights of society, those being, to

> …not broadcast any material which is indecent or obscene or offensive to public morals or offensive religious convictions or feelings of any section of a population or likely to prejudice the safety of the State or the public order or relations between sections of the population…

In *Organisasie vir Godsdienste-Onderig en Demokrasie (OGOD) v Laerskool Randhart*,[261] there was a challenge to the constitutionality of public schools promoting a particular religion, that being, Christianity. The applicant argued that this violated the right to freedom of religion and prohibition of religious discrimination. The court ruled that public schools may not favour one religion over others and that the constitutional principles of equality and religious freedom must be upheld.

Christian Education South Africa v Minister of Education[262] highlighted the conflict between religious freedom and the state's interest in regulating religion. The matter involved Christian Education South Africa challenging the constitutionality of the SA Schools Act, 1996, which prohibited corporal punishment in schools. The association argued that corporal punishment was an integral component of their belief system and that the prohibition violated their right to religious freedom. The Constitutional Court applied the limitation clause of the Constitution, based on human dignity, equality and freedom, to protect children's rights to be free from

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260 *Islamic Unity Convention v Independent Broadcasting Authority* ZACC (3) 2002 (4) SA 294 (CC).

261 *Organisasie vir Godsdienste-Onderig en Demokrasie (OGOD) v Laerskool Randhart* ZAGPPHC 160 2017 6 SA 129; (2017) 3 All SA 943 South Gauteng High Court.

262 *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC).

violence and to have their dignity respected. The ruling emphasised the rights of children and outweighed the religious rights of parents and schools.

In the case of *Garden Cities Incorporated Association Not for Gain v Northpine Islamic Society,*[263] concerning property rights, religious freedom and contractual obligations, the court addressed a restrictive covenant in the sale agreement which prohibited the use of land for religious purposes. The court held that the contractual obligations must be respected and that the restrictive covenant was enforceable.

In *Freedom of Religion South Africa v Minister of Justice and Constitutional Development and Others,*[264] the Constitutional Court dealt with the right to child punishment in the home environment. The case arose from the criminal conviction of a father who had used corporal punishment on his son as a form of discipline. The father argued that his actions were in accordance with his religious beliefs, which permitted corporal punishment as a necessary part of child rearing. For his defence, the organisation, Freedom of Religion of South Africa argued that 'reasonable chastisement' should be a parental prerogative as part of their religion. The Constitutional Court unanimously ruled that the common law defence of 'reasonable chastisement' was unconstitutional and held that all forms of violence against children, including corporal punishment, violated the rights of children to dignity, and protection from abuse. This case was significant in its ruling in that it provided further clarification in respect of religious freedom, where religious practices that infringed on the rights of others, inclusive of children, were subject to limitation.

In *Re C (Adoption: Religious Observance)*,[265] involving an adoption of a child, the High Court ruled against the rights of parent's religious freedom in favour of the child's welfare for a stable and loving environment and other emotional, cultural and religious needs. In *Re E (An Infant)*[266] where the issue involved wardship proceedings to find religiously compatible adopters of the child, the Court emphasised the religious upbringing of the child as expressed by the mother. The ruling held the mother's preference, stating wardship should continue,

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263 *Garden Cities Incorporated Association Not for Gain v Northpine Islamic Society* 1999 (2) SA 268 (C).

264 *Freedom of Religion South Africa v Minister of Justice and Constitutional Development and Others* 2019 ZACC 34.

265 *Re C (Adoption: Religious Observance)* 2002 1 FLR 1119.

266 *Re E (An Infant)* 1964 (1) WLR 51.

thereby supporting her request to prevent the child's adoption into a different religious background.

3.5 Adults Jehovah's Witnesses rights to refuse blood transfusions

In this section, the rights to religious objection are discussed in the context of specific medical interventions and treatment, such as blood transfusions. The refusal of blood transfusions has been discussed extensively in the context of Jehovah's Witnesses. Treating Jehovah's Witnesses patients have culminated in numerous ethical dilemmas and controversies. Jehovah's Witnesses patients do not refuse medical treatment and consent to a vast majority of medical treatments that do not contain blood or blood products. They accept alternatives to blood or blood products and do not choose to die.[267] Often, doctors may be presented with a Jehovah's Witnesses patient who would require life preserving procedures where consent is withheld by the patient. The freedom of religion establishes a right of choice and a corresponding right to refuse or object based on religious grounds. This right to religious objection would not only be consistent with the rights of freedom of expression of religious beliefs, but also with the rights to physical and psychological integrity, which confers the bearer of the right to have control over their own body. Therefore, provided that the patient understands the implications of their decision, the patient may refuse treatment. While the doctor has a duty of beneficence and non-maleficence, 'the religious adherent is that the patient is master of their destiny' irrespective of such refusal having the consequences of progression and further deterioration of illness and even death.[268] Therefore, the patients' autonomy needs to be respected. It is essential to recognise that obtaining consent is an integral component prior to the commencement of any examination, investigation, planned treatment, procedural intervention, or surgery, as failure to do so would be tantamount to an act of assault, as discussed in Chapter two of this mini-dissertation.

Doctors often experience dilemmas when the duty of providing treatment and care without concern of interest for third parties comes into conflict with patient autonomy. This conflict is often experienced by Jehovah's Witnesses patients when the patient's consent and demands comes into conflict with ethical and professional obligations.

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267 J L Letsoalo 'Law, Blood transfusion and Jehovah's Witnesses' (1998) 17 *Med Law* 633-638.

268 G Van der Schyff 'The right to religious objection in South African Law' (2002) 19(3) *SALJ* 526-533.

Jurisprudence in various jurisdictions have dealt with the request of refusal of blood transfusions inclusive of the risk of dying. This has raised numerous legal and moral questions throughout the world. When the patient is competent, has no children and is not pregnant, autonomy and self-determination would supersede the countervailing state's interest, even if the consequences lead to death.[269]

In *Public Health Trust of Dade County v Wons*,[270] Mrs Wons, a practicing Jehovah's Witness and mother of two, presented to the hospital with dysfunctional uterine bleeding and refused a blood transfusion. Mrs Wons' husband supported this decision. The Health Trust petitioned the court, which subsequently ordered a blood transfusion while Mrs Wons was unconscious. Upon waking, Mrs Wons appealed the order, which was reversed by the district court and whose decision was affirmed by the Supreme Court of Florida, that the patient's constitutional rights to religious freedom and privacy could not be overridden by the state's interest.

In *United States v George*,[271] a practicing Jehovah's Witness and father of four children was admitted to the Veterans Administration Hospital with a bleeding gastric ulcer and had refused a blood transfusion; he was deemed to require five units of blood to preserve his life. The hospital instructed its attorneys to apply to the United States District Court for urgent intervention and the blood transfusion was authorised after the patient conceded that he would not oppose receiving a blood transfusion, if authorised by the court. The court reasoned concern for the doctor's position; while the patient consented to treatment, the doctor could not dictate to treatment that would constitute mistreatment.

In the courts of England and Wales, the case of *Re T (Adult; Refusal of Treatment)*,[272] the court ruled that the refusal of a blood transfusion would be legally binding on doctors if the patient's refusal is considered competent, if the patient comprehends the decision made in light of the information given, and the decision is free of any coercion. Lord Donaldson stated:

> This situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient's interest consists of his right to self-determination—his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society's interest is in upholding

269 G Koeneke 'Jehovah's Witness and the refusal of blood transfusion: a Balance of interest' (1990) 33 *Catholic lawyer* 361.
270 *Public Health Trust of Dade County v Wons* 500 So 2d 679 (Fla Dist Ct App 1987).
271 *United States v George* 239 F Supp 752 (District Court Conn 1965).
272 *Re T (Adult; Refusal of Treatment)* 1992 (4) All ER 649 (CA).

> the concept that all human life is sacred and should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount.

This was further elucidated in *Nottinghamshire Healthcare Trust NHST v RC*,[273] where a man who slashed his brachial artery had been retained under the Mental Health Act of 1983, and where the court deemed that the administration of blood would be an abuse of authority, as the man had provided a valid advanced directive to refuse a blood transfusion. Similarly, in *St George's Healthcare Trust NHST v S*,[274] the court ruled that a pregnant Jehovah's Witnesses mother's refusal of a blood transfusion and caesarean section should be upheld, even though it would result in the death of her unborn child, because the patient had the right to self-determination and can choose for herself.

The case of *Philips v De Klerk* recognised the rights of an adult person to refuse a blood transfusion. Phillips, who was involved in a motor vehicle accident and who was fully conscious on admission, had indicated his refusal of a blood transfusion to the staff. Although the initial order was based on the urgency to administer a blood transfusion, no blood transfusion was administered to the patient. The patient brought an application several months later to the Supreme Court contesting the violation of his personality rights. The prior order was rescinded and the judge opined that the doctor does not have the right to treat the patient against his will. In the absence of:

> overriding social interest or interest of a minor who is dependent on the adult, a mentally competent person has the right to control his own destiny in accordance with his own value system which should be rated higher than his health and life.[275]

According to the National Health Act, a mentally competent patient has the right to refuse medical treatment provided the implication, risk, and obligations of such a refusal is explained to the patient.[276] However, as discussed earlier, this right is not absolute and may be subject to limitations, which will be discussed below.

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273 *Nottinghamshire Healthcare Trust NHST v RC* 2014 EWCOP 1317.

274 *St George's Healthcare Trust NHST v S.* 1999 Fam 26 (CA).

275 Cf. F Mnyongani & M Slabbert 'A Jehovah's Witness autonomy versus the interest of her children' ES v AC (SA 57/2012) [2015] NASC 11. *Philips v De Klerk* (unreported March 1983 (T)) in Strauss 'Doctor, *patient and the law'* 1991 29-34.

276 S 6(1)(d) of National Health Act 61 of 2003.

3.6 Limitation of parental rights to religious objection for medical treatment of children

The concept of *parens patriae* was highlighted in *R v Gyngall* where the state's authority was regarded as paternal jurisdiction where the 'Chancery Court could act on behalf of the Crown in place of the parents and superseding the natural guardianship of the parent'.[277] It is regarded as a practical jurisdiction that exercises more authority than parental rights and is composed of the common law rather than statutory provisions.[278] The legal doctrine confers the 'state the authority, in appropriate circumstances, to intervene in parent-child relationships' in order to protect the interests of the child, especially in the circumstances of health and welfare of the child, where there is a need for lifesaving and therapeutic interventions. Fundamentally, no parental authority is absolute and may be limited. The judgments in various jurisdictions also have been instructive and influential in the South African setting, especially the judgements in the United States of America and United Kingdom, where the courts ordered blood transfusions despite the religious objections by their parents. This will be further discussed in the context of *parens patriae* in various jurisdictions.

3.6.1 United States of America

Courts have ordered blood transfusions for numerous indications where the child's life is in danger, irrespective of the clinical condition, in order to preserve the life of the child in instances of medical emergency. Where the child's life is not in danger, the decision to administer a blood transfusion may not be necessarily clearly defined. In the United States of America, the courts took into consideration the parent's religious interests and rights to make decisions about their child, the benefit that conferred to the child, and the child's autonomy in decision-making based on maturity. This will be further discussed in chapter four. The courts may also overrule the parent's desire to respect their religious freedom and refusal of blood transfusions in instances of irreparable harm[279] or in the instances where the risk of surgical intervention warrants a good clinical outcome.[280]

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277 *R v Gyngall* 1983 (2) QB 232.

278 Medical Discrimination Against children with Disabilities: A Report of the United States commission on Civil Rights September (1989).

279 *Muhlenberg Hospital v Patterson* 1974 128 NJ Super 498 A 2d 518 in D McQuoid-Mason & L Lotz 'Religious beliefs and the refusal of blood transfusion for children: What should doctors do?' (2005) 68 *THRHR* 315-321.

280 *In Re Sampson* 1972 29 NY 2d 900, 278 NE 2d 918 in D McQuoid-Mason & L Lotz 'Religious beliefs and the refusal of blood transfusion for children: What should doctors do?' (2005) 68 *THRHR* 315-321.

While children may share similar, numerous rights when compared to adults, these rights are subject to limitation when there is potential harm as a consequence to the exercise of these rights. In *Prince v Massachusetts*,[281] the guardian, Sarah Prince, was a practicing Jehovah's Witness and an ordained minister, and was convicted for violating child labour laws by bringing a child of nine years of age to preach on the streets and distribute literature in exchange for voluntary contributions. Prince argued that the state's labour laws violated her Fourteenth Amendment rights to exercise her religious rights. The court ruled that the state was free to legislate against religious freedom, which would otherwise be prohibited. The court stated that the 'family is not beyond regulation in the public interest as against a claim of religious liberty and neither the rights of religion nor the rights of parenthood are beyond limitation'. The court stated that 'parents may be free to become martyrs themselves but not allowed in identical circumstances to make martyrs of their children'. A priority therefore exists that the best interests of the child are always of 'paramount importance' in all matters related to children.

In *People ex rel. Wallace v Labrenz*,[282] the court held that while religious freedoms are protected by the American Constitution and parents may rely on the Free Exercise Clause of the First Amendment, when applied to the refusal of a blood transfusion for their infant, ruled that the constitutional freedoms cannot extend to practices that would harm the life and health of the child. Similarly, in *Morrison v State*,[283] the court acknowledged the religious beliefs of the parents but stated that since the parents are not the recipients of the blood, they cannot be affected by the administration of blood to the child. The court ruled that 'one may not prevent another person, a citizen of our country from receiving medical attention necessary to preserve her life'. Hence, the court ordered a blood transfusion for the child. The failure of the children to receive blood transfusions can also be regarded as neglect in the American courts as indicated in *Santos v Goldstein*.[284]

In *MN v Southern Baptist Hospital of Florida Inc*,[285] the court overruled the parent's refusal of blood transfusions. The court considered numerous factors that needed to be taken into consideration, namely,

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281 *Prince v Massachusetts* 1944 321 U.S. 158.
282 *People ex rel. Wallace v Labrenz* 104 N.E.2d 769 (OL 1952).
283 *Morrison v State* 252 S.W.2d 450 (NY 1962).
284 *Santos v Goldstein* 227 N.Y.S.2d 450 (NY 1962).
285 *MN v Southern Baptist Hospital of Florida Inc* 648 So 2d 769 (Fla Ct App 1994).

> parental interest in the parental role of decision maker for the medical care of the minor, the state's interest in preserving human life, the child's own welfare and interests, the severity of the child's illness, the probability or likelihood that the treatment will be effective, the survivability of the child with and without treatment and the invasiveness and nature of the treatment and effect on the child.[286]

In *Application of the President and Directors of Georgetown College Inc*,[287] a Jehovah's Witness mother of a seven-month-old child had presented with a ruptured peptic ulcer and had lost about two thirds of her blood, but refused an urgent need for a blood transfusion that would preserve her life. The hospital sought an urgent injunction and Judge Wright, upon visiting the patient in hospital, authorised the blood transfusion. In his judgement, the judge examined the state's duty in protecting minor children and that the mother had a duty to society to care for her child. Judge Wright in his remarks stated that when 'a life hung in balance there was no time for research and reflection and action was necessary to preserve the status quo and to act on the side of life'.

The principles gathered from jurisprudence in the United States of America established that while the adult has a right to refuse medical treatment, this right is not absolute and that the state could intervene in a given case if the state's interest outweighs the interest of the patient in refusing medical treatment, whether this refusal is based on the common law or constitutional principles. Moreover, the countervailing interests of the state may override the expressed wishes of the patient. These include the interest in the preservation of life, the need to protect innocent third parties, such as children, the duty to prevent suicide, and the need to preserve the ethical integrity of the medical practice. Therefore, should there be a refusal of medical treatment that would result in the abandonment of children, the courts may intervene to order a blood transfusion. This compelling interest of the state to override the wishes of the patient may be determined on the circumstance of each individual case based on merit.[288]

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286 D McQuoid-Mason, L Lotz 'Religious beliefs and the refusal of blood transfusion for children: What should doctors do?' (2005) 68 *THRHR* 315-321.

287 *Application of the President and Directors of Georgetown College Inc* 331F.2d 100 (D.C. Cir) cert. denied, 377, U.S. 978 (1964).

288 M Tshimanga & S Baloyi 'A Jehovah's Witness with haemolytic anaemia in pregnancy refuses blood transfusion: A case report' (2020) 30(1) *O&G Forum* 26-30.

3.6.2 Canada

There have been instances in Canada where parents have withheld consent for their disabled children in the belief that it would be better for the children to die.[289] The courts have upheld the right to life and appropriate treatment. There have been numerous cases in Canada where the parents have refused blood transfusions based on the Canadian Charter of Rights and Freedoms. The courts have recognised parental rights to choose medical care for their children in accordance with their religious beliefs, provided this does not override the state's concern with the life and health of the child. In *B(R) v Children's Aids Society in Metropolitan Toronto*,[290] the prioritisation of the child's right to life and limitation of Jehovah's Witnesses parental religious beliefs, especially in emergency situations, was highlighted when the court upheld the Children' Aids Society's decision to intervene and ensure that the child received the necessary medical treatment and blood transfusions. In this instance, the decision of the Ontario Court of Appeal was upheld by the Supreme Court of Canada. This case highlighted the legal framework related to religious objections to blood transfusions in Canada and balancing the rights to freedom of religion with concerns of life and health, especially involving children with life-threatening situations.

3.6.3 United Kingdom

Specifically related to medical decision for minors based on religious beliefs, no decision in the United Kingdom can be based on religious grounds as this would be considered as a criminal offence as elucidated in *The Queen v Robert Downes*[291] and *R v Senior*.[292] In *The Queen v Robert Downes*, the father who was a member of 'Peculiar People' religious sect was charged with manslaughter when his child demised as a result of neglect and malnourishment, as a consequence of his rejection of conventional medical treatment in favour of the belief that his child could be healed based on his reliance on the cure based on prayer. Similarly, in *R v Senior* the father, Senior, based on his religious beliefs, relied on prayer rather than conventional medical treatment. The child subsequently demised as result of his illness and Senior was charged with manslaughter.

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289 *Saskatchewan (Minister of Social services) v P.* 1990 (F) 69 D.I.R (4th) 45; *Coutre-Jacquet v Montreal Children's Hospital* (1986) 28 D.I.R (4th) 22.

290 In *B(R) v Children's Aids Society in Metropolitan* Toronto (1995) 1 S.C.R. 315.

291 *The Queen v Robert Downes* (1875-1876) L.R. 1 Q.B.D. 25.

292 *R v Senior* (1899) 1 QB 283.

While the courts in the United Kingdom recognise parental rights with respect to decision-making, the courts always act in the best interests of the child. Where there is conflict between the treatment of the child and the parental opinion, the courts rule against the parents where the child's interests are concerned. This was elucidated in *Re C*[293] where the court ruled against Jewish parents in life sustaining treatment. Conversely, the courts may also rule in favour of the parents, as elucidated in *An NHS Trust* v *MB*,[294] where the court ruled that withdrawing treatment may not be in the best interests of the child, as the child 'felt pleasure in being around the parents'. The courts have also acknowledged that the limits of *parens patriae* could only be applied where the child's welfare was threatened by serious and impending risk of grave and irreversible mental or physical harm, as elucidated in *Re W*.[295] In *EE (A Minor)*,[296] the Jehovah's Witnesses parents of a fifteen-year-old boy with leukaemia refused a blood transfusion. The local authority made the boy a ward of the court and ruled that the patient had not reached the statutory presumption of capacity to consent and rejected the parents' refusal of blood transfusion based on the welfare of the child. Similarly, in *Re S (A Minor)*,[297] the court ruled that the wellbeing of a four-year child took precedence over parental objection based on religious beliefs of refusal of blood transfusions and absolved the parents of any guilt for flouting religious beliefs. The best interests of the child were also elucidated in *Re R (A Minor)*[298] wherein the parents of Jehovah's Witnesses' objection to a blood transfusion in a child was overruled.

3.6.4 Australia

In *Hunter New England Local District v JI & Ors*,[299] the court invoked the *parens patriae* jurisdiction, wherein parents of a three-year-old child of Jehovah's Witnesses refused a blood transfusion for two surgical procedures to be performed. The child was born with serious medical conditions, including an omphalocele, renal abnormalities, cardiac defects and development dysmorphism, which resulted in numerous complications, such as malrotation, abdominal hernia and was dependant on tube feeding. The parents consented to two surgical procedures but not to a blood transfusion. The issue of concern was whether the doctors could treat the child with blood products without the parent's consent. To make its decision the court

293 *Re C* (*A Minor*) (Withdrawal of Lifesaving Treatment) (1998) 1 FLR 384-389.
294 *An NHS Trust v MB* (2006) 2 FLR 384-389.
295 *Re W (A Minor*) (Medical Treatment: Courts Jurisdiction) (1993) Fam 64.
296 *EE (A Minor)* 1 FLR 386, 1993.
297 *Re S (A Minor)* (Medical Treatment) (1993) FLR 376.
298 *Re R (A Minor)* (Medical Treatment) (1993) 2 FCR 544.
299 *Hunter New England Local District v JI & Ors* (2023) NSWSC 1245.

considered the case of *Re Alex*,[300] which took into consideration the nature of the medical treatment, the reasons for the treatment, the inherent risk to the child without the proposed treatment, alternative courses of treatment that were available, the views and faith of the child's parents, and the views of the treating doctors. Prior to administration of treatment, the healthcare professionals needed to be satisfied that a blood transfusion was necessary and that they avoided unnecessary use of blood transfusions and explored alternative treatments, including blood conserving strategies.

3.6.5 Nigeria

In the case of *Tega Esabunor v Fayewa and Ors*,[301] the Supreme Court of Nigeria dismissed an application to overrule the Magistrate Court's decision to order a blood transfusion for a child about a month old. The case involved a child who became critically ill within the first month after being born and was taken to hospital for treatment. The parents of the child refused a blood transfusion based on their religious beliefs. The police, guided by the Children and Young Person's Law[302] of Nigeria, applied for an urgent court order which granted an order for the child to receive a blood transfusion. The child improved and was subsequently discharged. The parents subsequently requested a *certiorari* from the Supreme Court to rescind the lower court's decision, claiming a lack of jurisdiction and sought damages for an unlawful blood transfusion without consent. The Supreme Court ruled that it was paramount to save the life of the child when faced with parental refusal of blood transfusions and medical treatment based on religious beliefs. The *parens patriae* role of the lower court was upheld and the court cited the Nigerian Criminal Code and Nigerian Constitution where the right not to be deprived of life and the right not to be intentionally deprived of life is guaranteed. Therefore, the court opined that to refuse a child to the right to life by refusal of a blood transfusion would constitute a felony.

3.6.6 Namibia

The case of *ES v AC*,[303] highlighted the conflict between protecting the rights of the parent and the best interests of children. In *ES v AC*, the case was brought by mother of three, Mrs *ES*, who was a practicing Jehovah's Witness. Mrs *ES* appealed against the High Court on an earlier

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300 *Re Alex* (2004) 180 FLR 89.
301 *Tega Esabunor v Fayewa and Ors* (2019) LPERL 46961 (SC).
302 S 27(1) and S (30) Children and Young Person's Law Cap 1 Laws of Lagos State (1973).
303 *ES v AC* (SA 57/2012) (2012) NASC 11 (2015).

judgement where court directed against her brother, *AC*, who was appointed as curator to Mrs *ES* and where the court directed the treating doctor or any other medical practitioner to render appropriate medical treatment including a blood transfusion. The case involved the patient, who at eight months gestation, needed an emergency caesarean section. Prior to surgery, the patient indicated to the anaesthetist that she was a Jehovah's Witness and had refused a blood transfusion. The patient complicated and needed an emergency hysterectomy which was authorised by her husband who had durable power of attorney. Post operatively, the patient was admitted to intensive care and her haemoglobin had dropped to critical levels and was in urgent need for a blood transfusion. The High Court judgement rested on two important aspects, namely, that the patient was not *compos mentis* to exercise her right to refuse a blood transfusion, and that the freedom of autonomy should be considered against the unborn child, her two older children, and the interests of her wider family and society in general. The application by *AC* was supported by the treating physician in his submission that the patient was not *compos mentis* based on the lack of oxygen supply to the brain. Based on this submission, the blood transfusion was authorised. The majority view in the appeal was that patient autonomy was the overriding principle, based on the Namibian Constitution, and the submission that the Constitution 'anticipates circumstances, unforeseen and otherwise that may prevent children being raised by their natural mother and father'.[304]

3.6.7 South Africa

In *Hay v B*,[305] the parents of the child refused a blood transfusion to save the life of the child based on religious grounds and the concern of contamination of the blood and infection. The court authorised the blood transfusion and, in his judgement, Jajbhay J, based his decision on section 28(2) of the Constitution where the child's best interests was paramount and stressed the importance of the right to life based on section 11 of the Constitution. While the parent's religious beliefs and concerns were recognised and respected by the court, the court ruled that the interest of the child in receiving an urgent blood transfusion superseded the religious beliefs and reasons given by the parents. The court, in its decision, considered similar approaches in other jurisdictions and referred to 'The doctors dilemma: duty and risk in the treatment of Jehovah's Witness' by Michael Katz'.[306] This judgement predated the Children's Act and was

304 Cf. F Mnyongani & M Slabbert 'A Jehovah's Witness Autonomy versus the interest of her children' (2018) 81 *THRHR* 316.

305 *Hay v B* 2003 3 SA 494 (W).

306 M Katz 'The doctors dilemma: duty and risk in the treatment of Jehovah's Witness' (1996) 113(3) *SALJ* 484-495.

significant in the application the Children's Act in reference to section 129(10) of the Children's Act and parent's making decisions for their children based on religious grounds.

In *Life Healthcare Group (Pty Ltd) v JMS*,[307] the issue presented before the Court was to authorise medical treatment and a blood transfusion in a child to preserve the child's life despite the parent's religious objection. A child of three weeks was delivered by caesarean section at twenty-nine weeks gestation. The child was facing imminent cardiac and respiratory failure and was in urgent need of a blood transfusion. The response to the treatment with a blood transfusion was not guaranteed. The parents requested all alternatives to be considered to preserve the life of the child. The application was brought by Life Healthcare and Doctor Moodley who testified at the proceedings. The Court ruled to authorise a blood transfusion and held:

> that the parents' right to religion is not unfettered, that the right to life is an inviolable right and to the extent that the parents right potentially violates the child's right to life, it is in the best interest of the child that the child's right to life is protected. The content of the child's right to life includes the right to receive medical treatment, especially where such treatment would preserve the child's life.

The court, in its ruling, referred to the consent provisions in section 129 and section 126(9) of the Children's Act, which gives the High Court or the Children's Court jurisdiction to consent to the medical treatment of a child in instances when the authorised person refuses or is unable to give consent. Based on section 129(10), the refusal of consent based on religious grounds was deemed unlawful.

The rights of parents and guardians to choose or refuse medical treatment, such as blood transfusions for children, may be limited to protect the interests of the child. The doctrine of necessity would arise in cases of medical emergencies where urgent intervention would be required to preserve life or avoid serious injury**.** Specifically, relating to blood transfusions, should there be a medical emergency and where the child's life is in danger, the Constitution provides for that no one may be refused emergency medical treatment.[308]

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307 *Life Healthcare Group (Pty Ltd) v JMS* 2014 JDR 2391 (GJ).

308 S 27(3) of The Constitution of the Republic of South Africa, 1996.

3.7 Conscientious objections by healthcare professionals

Healthcare professionals are bound by their ethical and constitutional obligations to ensure that their constitutional rights to freedom of conscience, thought, belief and opinion is not exercised in a manner that is contrary to the Bill of Rights.[309] Bioethical principles of beneficence, non-maleficence and justice should always prevail to ensure that they always act in the best interests of patients and the 'obligation to respecting human life'.[310] The Constitution guarantees the rights of access to healthcare,[311] including that of children,[312] the right to life[313] and not to be refused emergency medical treatment.[314] In circumstances where an administration of a blood transfusion is refused by a healthcare professional on grounds of religious beliefs, and the decision by the healthcare professional not to render treatment, the courts would consider the practitioner's knowledge of the patient's condition, the seriousness of the patient's condition, the professional ability of the practitioner, the physical state of the practitioner, the availability of other practitioners, the interests of other patients of the practitioner, and the consideration of professional ethics. Therefore, in instances of a medical emergency and the failure to administer a blood transfusion, where the healthcare practitioner has knowledge of the seriousness of the patient's condition and where no other practitioner is available or without appropriate referral to another practitioner, this would be considered *contra bonos mores* and delictual conduct should there be an adverse event.[315]

3.8 Conclusion

For society to function normally, there should be consistency, conformity to and respect for the law, especially the fundamental rights. There is no automatic right for exemption from legislative and the common law requirements in favour of religious practices. In instances where religious practices are inconsistent with the provisions of the Bill of Rights, they are more likely to be restricted than other rights due to the state's obligation to prevent practices that could cause harm to society. It is submitted that the right to practice one's religion requires careful consideration when evaluating 'faith with reason' and distinguishing religious activities

309 S 15 Chapter 2 (Bill of Rights) of The Constitution of the Republic of South Africa, 1996.
310 World Medical Association International Code of Ethics (2006).
311 S 7(1) of The Constitution of the Republic of South Africa, 1996.
312 S 11 of The Constitution of the Republic of South Africa, 1996.
313 S 28(3)(a) of The Constitution of the Republic of South Africa, 1996.
314 S 27(3) of The Constitution of the Republic of South Africa, 1996.
315 D McQuoid-Mason 'May doctors for religious reasons refuse to give patients' blood transfusions under any circumstances' (2019) 82 *THRHR* 478.

from those that are not. Although these principles apply mostly to adults, particularly in the context of Jehovah's Witnesses' refusal of blood transfusions, elucidated in the supervenient discussion, it should be emphasised that when religious rights conflict with the fundamental rights of children, the rights of children take precedence over parents' religious beliefs.[316] The next chapter considers the decision-making capacity of minors and the rights to self-determination of the mature minor.

316 B Bekink 'Parental religious freedom and the rights and best interest of children' (2003) 2 *THHR* 252-253.

CHAPTER 4: CHILDREN AND BLOOD TRANSFUSIONS

4.1 Introduction

Globally, considerable progress has been made in recognising and upholding the rights of children and adolescents to make decisions. The previous chapter has elucidated the rights of parents to make decisions on behalf of their children who lack capacity, provided these decisions are in the best interests of the child. However, along with the child's advancing age and maturity, comes evolving capacities and greater significance to the child's rights to autonomy. It is submitted that children's participation in decision-making in conjunction with parents and healthcare professionals, not only improves treatment outcomes, but also, promotes a sense of control resulting in positive adjustment and enhances understanding of their illness and compliance with prescribed medical treatments inclusive of instances where consent may not be required.[317]

The doctrine of necessity allows doctors to administer treatment in emergencies where immediate action is essential to preserve life or prevent irreversible harm. Overriding a patient's autonomy, whether for an adult or a child, must be justified based on legal requirements or public policy. The doctrine of necessity permits doctors to administer treatment in emergency circumstances, where immediate action is essential to preserve life or prevent irreversible harm. This permits medical intervention within the scope of what is considered medically necessary under such urgent circumstances. There must be a necessity to act in circumstances where it considered not practicable to communicate with the person requiring assistance and the action taken must be as a reasonable individual would take in all circumstances acting in the best interests of the patient. In comparison, *negotiorum gestio,* rooted in Roman-Dutch law, applies in situations where an emergency necessitates intervention. It requires that the person executing the decision to act does so under circumstances where the patient is unable to consent or unaware of the situation. Any intervention must not contradict the patients previously expressed will. It is submitted that the legal concept of best interests promotes patient autonomy where any 'action or omission',

317 H Kruger 'The Realization of Children's Rights to Participate in Selected Medical Decisions in South Africa' (2018) 135(1) *SALJ* 73.

maximises the well-being of an individual in a particular situation or would subjectively depend on a competent individual's decision and choices.[318]

The decision-making capacity of children remains a central aspect to determine the autonomy of children. To explore the rights of children to consent or refuse treatment, this chapter will cover the decision-making capacity, and the rights of autonomy based on international and South African perspectives.

4.2. The decision-making capacity of children

Regarding medical decision-making of children, the primary focus is to protect children from their own 'immaturity of judgement'. There has been significant progress made in the relaxation of children's capacity to consent to certain 'juristic acts' and these are attributed to numerous factors. These include 'global reordering of the parent child relationship' in conjunction with recognition of the child as an autonomous person, depending on the issue of concern and the age and maturity; the involvement of children's rights movements; extensive research on children's level of maturity; the position in South Africa of the fundamental rights determined in the Bill of Rights and the ratification by South Africa of regional and international instruments protecting the rights of children.[319]

As elucidated in chapter two, for consent to be considered 'informed' would require the fulfilment of key elements for adequate information disclosure, there must be the capacity to understand the information; decision should be bereft of any coercion or deception; and, there must be understanding of the information provided and agreement to the proposed treatment or procedure.[320] A patient's ability to decide would depend on the patient's individual ability based on the possession of set values and goals, inclusive of the ability to communicate and understand the information provided and the ability to reason and deliberate about one's choices, whether good or bad. The patient needs to make consistent choices. Basic understanding would require various linguistic, cognitive and conceptual skills which are dependent on sufficient life experiences to appreciate the treatment and the ability to compare treatment and alternatives on 'personal goals and life plans'. The actual determination capacity

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318 S C Chima *An Investigation of informed consent in clinical practice in South Africa* (Doctor of Laws, University of South Africa, 2018) 124-131.

319 H Kruger 'Protection of children's right to self-determination in South African Law with specific reference to medical treatment and operations' (2018) 21 *PELJ* 2.

320 S C Chima 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) *BMC* 14 (Suppl 1), S3.

in adults is not a simplified process and adults may not be consistent in the performance of specific tasks.[321]

To ascertain whether the patient lacks capacity for decision-making entails taking cognisance of best interests and the right to self-determination. In circumstances where there are detrimental consequences to the person's wellbeing, this would necessitate a greater degree of scrutiny and determination of capacity. It is submitted that the 'expressed preference standard' does not necessarily equate to the patient's best interests. Conversely, the 'objectively correct decision standard' places decision-making in the hands of the healthcare professional or other third parties in circumstances where decisions appear incorrect, irrational and incompatible to the healthcare professional, which could conflict with the right to self-determination.[322] Buchanan and Broc state that competence in decision-making would depend on a particular decision under specific circumstances. The authors, identify capacities needed for decision-making, which includes capacity for understanding and communication, the ability for reasoning and deliberation, inclusive of a set of values and a concept of what is good. The ability to comprehend is not only a formal process but is inclusive of the ability to appreciate the nature and meaning of potential alternatives. It is submitted that children lack this level of understanding due to their relative lack of life experiences. Competence requires capacities for reasoning and deliberation and the ability to draw inferences about the consequences of making a particular decision and comparing outcomes. Consistency and a stable set of values allows for the decision-maker to determine the significance in relation to benefits or detriments to the decision made.[323]

Numerous factors are required to be considered when acting in the best interests of the child, as elucidated in the Children's Act.[324] It is submitted that mental capacity also relates to decisional capacity. Factors that influence children's ability to make decisions, relate to the circumstances of the child, healthcare provider, parents, and the treatment decision made. Children's experiences and exposure to illness, hospitalisations and medical interventions are more likely to provide a better understanding of health-related matters. Additionally, experiences related to disability and illness increases children's knowledge, ability, skill and

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321 Kruger (note 319 above; 2).

322 Michigan Law Review *Making Health Care decisions. A report on 'The ethical and legal implications of informed consent in the patient practitioner relationship'*, Presidents' Commission for the study and of ethical problems in medicine and biomedical and behavioural research (1998) 55-68.

323 Kruger (note 319 above; 7).

324 S7 of Children's Act 38 of 2005.

resolve to deal with these afflictions. Parental involvement, attitude and support influences children's capacity to consent and a nurturing relationship is more conducive for autonomous decision-making. The degree of complexity, magnitude and circumstances relating to medical or surgical treatment would require a greater degree of maturity and capacity. Capacity may be influenced by prevailing circumstances such as pain at the time, fear, fatigue, or the effect of medication.[325]

Piaget believed that children of varying ages made mistakes because of the 'quality rather the quantity of their intelligence'.[326] Piaget described four stages of cognitive development, ranging from the sensorimotor, pre-operational, concrete, to the formal operational stage. Piaget described cognitive development as a progressive reorganisation of mental processes, resulting from 'biological maturation and environmental experience'. Piaget noted that the preoperational stage commences after the child begins to speak and lasts up to the age of seven years. This stage is characterised by the lack of comprehension of concrete logic and the lack of assimilation of information. The concrete operational stage occurs between the ages of seven and eleven years and is characterised by a child learning progressive rules of conservation, the ability to incorporate inductive reasoning from observations in order to make generalisations but without the ability of 'deductive reasoning'. The formal operational stage commences from eleven years and reaches equilibrium about the age of fourteen where intelligence is demonstrated through 'logical use of symbols related to abstract concepts'. This stage is characterised by drawing conclusions from the information available and applying this to hypothetical situations. This theory has its limitations based on the defined stages of development and does not necessarily take cognisance of the continuous development process of cognitive realization and maturity which underestimated children's abilities. A study conducted by Weithorn et al measuring the competency of children without any illnesses and their treatment decisions based on hypothetical scenarios found that children by the age of nine were capable of understanding simple health related matters though less competent than adults, and that by the age of fourteen, developed an adult level of understanding based on their ability.[327] A South African study by Van Heerden[328] showed that twelve and thirteen-year-old

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325 Y Havenga & M A Temane 'Consent by children: considerations when assessing maturity and mental capacity' (2016) 58(S1) *South African Family Practice* 43.

326 'Piaget's theory of cognitive development', available at https://en.wikipedia.org/wiki/Piaget's, accessed 6 October 2024.

327 L A Wiethorn & S B Campbell 'The competency of children and adolescents to make informed treatment decisions' (1982) 53(6) *Child Dev* 1589.

328 J Van Heerden 'Children's ability to consent to medical management in South Africa' (2020) 14(1) *SAJCH* 25.

children differed significantly from adults in their comprehension of abstract concepts. The study showed that children listed fewer factors in their decision-making process and did not discuss abstract concepts as comprehensively as adults. The study concluded that:

> basic choices regarding the administration of medicine and minor surgical interventions are in the decision-making for younger children, but psychiatric treatment and interventions with severe consequences are outside the scope of younger children's abilities.

Van Heerden expressed that complex decision-making as being 'questionable' and noted that due to promotion of confidence of children for decision-making in Westernised cultures differed when compared to non-Westernised cultures due to their hierarchal structures for elders to make decisions in a community setting. Strode is of the opinion that the current legislation is not in conflict with the findings of Van Heerden and that the drafters of the legislation, with references to the Choice Act, did not want the parental consent to be an obstacle to children obtaining medical assistance.[329]

4.3 The mature minor

4.3.1 The position in the United States

While parental consent is important, the development of progressive consensus in fields of law and medicine recognises minors with the capacity for decision-making. Commonly known as the mature minor doctrine, it recognises a minor's right to consent or refuse treatment if the child possesses sufficient maturity to understand and appreciate the benefits and risks of the proposed medical treatment. While initially invoked as means for the courts to rule on cases that failed to satisfy the emergency or medical necessity exception, the courts have since sought to address the question whether minors with capacity should be legally allowed to make decisions.[330] The American Academy of Paediatrics Committee Guidelines proposes that minors with decision-making capacity should be informed of their medical conditions and treatment options inclusive of refusing life sustaining treatment. The Guidelines define decision-making capacity:

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329 A E Strode … et al 'Adolescent self-consent to medical interventions in South Africa' (2023) 17 *SAJCH* 138.

330 M T Derish & K van den Heuval 'Mature minors should have the right to refuse life sustaining medical treatment' (2000) 28 *Journal of Law, Medicine and Ethics* 115.

> as the ability to understand and communicate information, the ability to reason and deliberate any matter concerning the decisions and the ability to apply the set of values to a decision that may be involve conflicting elements.[331]

In re E.G,[332] the rights of the mature minor to make critical medical decisions are accentuated. The case involved seventeen-year-old, *E.G*, who was a Jehovah's Witness, diagnosed with leukaemia and required chemotherapy and multiple blood transfusions to survive. The patient and her mother refused blood transfusions based on their religious beliefs. The case was initially brought before the courts as medical neglect proceedings against the mother. The mother was adjudged to be guilty of neglect and a blood transfusion was ordered. The subsequent judgement by the Supreme Court of Appeal ruled that the patient qualified as a mature minor based on the testimony of the treating physician confirming the patient's maturity and decision-making capacity which was corroborated by a psychologist. The court held that the age of majority was not a barrier to exercise the rights afforded to adults. Hence, the autonomy of the child to refuse a blood transfusion was given recognition by the court, but not regarded as absolute and could be overridden in situations where autonomy is exercised to the detriment of the child or society.

In *Belcher v Charleston Area Medical Center*,[333] the mature minor doctrine was recognised in a seventeen-year-old patient with muscular dystrophy who had suffered a respiratory arrest. The parents instructed not to resuscitate the patient if the patient gave such an instruction. The treating physician wrote a do not resuscitate order without the patient's consent and the patient suffered another respiratory arrest and subsequently demised. The West Virginia Supreme Court of Appeal ruled in favour of the parents in the lawsuit for failure to obtain consent from a mature minor prior to administering or withholding treatment.

Re Long Island Jewish Medical Center,[334] involving a seventeen-year-old Jehovah's Witness with metastatic cancer who required multiple blood transfusions to survive. The child with the support of his parents refused blood transfusions. The court ruled that the patient consulted his parents for all decisions and considered himself a child. The court ruled that the child failed to show maturity to substantiate the consequences of his actions and had little understanding of

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331 American Academy of Paediatrics Committee on Bioethics *Guidelines on forgoing Life-Sustaining medical Treatment* (1994) 532-536.

332 *Re E.G.* 549 N.E. 3d 322 (Ill. S. Ct. 1989).

333 *Belcher v Charleston Area Medical Center* 422, S.E.2d 827 (W. Va. 1992).

334 *Re Long Island Jewish Medical Center*, 557 N.Y.S.2d (N.Y. Sup. Ct. 1990).

his Jehovah's Witnesses faith except for the prohibition of blood transfusions. Moreover, the court exercised its *parens patriae* role and authorised the blood transfusion against the parental objections.

4.3.2 The position in the United Kingdom

The *Gillick v West Norfolk and Wisbech and the DHSS Area Health Authority*[335] case encapsulates the capability of the child to provide consent based on the evolving capacity of the child. The case involved Victoria Gillick, a Roman Catholic mother of five daughters, who were all younger than sixteen years of age, who sought assurance from the health authorities not to render advice or contraceptive treatment for her child without her expressed consent. She contested that the recommendation of the British Department of Health and Social Security was unlawful. It was adjudged by Lord Scarman that parental authority is not absolute, and the court's jurisdiction could be exercised if they are needed to protect the child. However, once the child acquires capacity or competency to decide, this would culminate in a limitation of parental authority for decision-making on behalf of their children. Known as '*Gillick* competence', it recognises that childhood is a developmental process from adolescence into adulthood. Once the child matures, the dynamics of parental authority evolves from exerting authority to advice and guidance. It is submitted that '*Gillick* competence' highlighted that the stage of development of the child should determine whether nurturance or self-determination approaches to protect children's interest should be adopted. In circumstances where the child lacks capacity for rational thought, the nurturance approach should be adopted. With the evolving capacity for rational thought, the self-determination approach becomes more relevant.[336] The standards recognise the child's legal competency to make decisions based on maturity, taking cognisance of the child's experiences and the ability to manage influences on their decision-making, free from the pressures of family and peers. Furthermore, it requires taking into consideration the child's level of intelligence and maturity for understanding of determining the risks and benefits when provided with information. '*Gillick* competence' therefore implies that where the child has sufficient understanding and intelligence to comprehend the nature and implications of the proposed treatment, the child is regarded as having a functional ability to decide. This is task-specific where more complex procedures require greater levels of competence and understanding, based on circumstances and proposed

335 *Gillick v West Norfolk and Wisbech and the DHSS* (1985) 3 All ER 402.
336 Kruger (note 319 above; 6).

treatment.[337] Therefore failure of the child to meet these requirements would lack the 'qualities of an autonomous individual'.[338]

In *Re T (Adult: Refusal of Medical Treatment)*,[339] a pregnant patient, who was at thirty-four weeks gestation, was involved in a motor vehicle accident and repeatedly refused a lifesaving blood transfusion after speaking to her mother who was of the Jehovah's Witnesses faith. The Court of Appeal held that although adults have the right to refuse treatment, this can be overridden in circumstances where there is confusion, unconsciousness, fatigue or shock, which may influence the decision-making capacity. For any decisions to be considered valid, healthcare professionals must consider whether the capacity was reduced and whether this decision was made independently, without coercion.

In *Re C (Adult Refusal of Medical Treatment)*,[340] the case highlighted that the presence of a mental illness did not negate capacity for decision-making. The case involved *C* with paranoid schizophrenia, who had developed gangrene in his leg, advised by doctors that without an amputation, he had an eighty-five percent chance of dying. *C* refused surgery and the hospital sought a court order to allow for surgery. The court ruled that *C* had the capacity to refuse treatment despite his mental illness, as he could comprehend the nature, purpose and risk of his treatment and therefore had the capacity to make an informed decision. Therefore, by inference, reduced decision-making capacity would exist in circumstances where there is a lack of comprehension of the potential benefits and risks of consenting or refusing treatment and a failure to assimilate the facts to arrive at a decision.

In *Re R*,[341] the Court of Appeal held that a fifteen-year-old girl, who suffered from serious mental health issues and suicidal behaviour, lacked the competence to consent or withhold treatment. It was acknowledged that although the patient had indicated her refusal in between her relapses, the patient's fluctuating nature of her illness rendered her incompetent to withhold treatment. The court ruled that the patient lacked sufficient understanding and intelligence and was not capable of formulating a decision based on the '*Gillick* competence' standard. The *Gillick case* also highlighted that having a mental illness is not regarded as a basis to deny

337 R Griffith 'What is Gillick competence?' (2016) 12(1) *Human Vaccines & Immunotherapeutics* 244.
338 B Clark 'My right to refuse or consent: The meaning of consent in relation to children and medical treatment' (2001) 64 *THRHR* 611.
339 *Re T (Adult: Refusal of Medical Treatment)* (1992) 4 All ER 649.
340 *Re C (Adult Refusal of Medical Treatment)* (1994) 1 WLR 290.
341 *Re R (A Minor) (Wardship: Consent to Treatment) (*1991) 4 All ER 627.

competency of the child in decision-making unless it is established that the mental illness is severe enough to affect the decision-making capacity.

In *Re E (A Minor)*,[342] a fifteen-year-old boy with leukaemia had refused a blood transfusion, was supported by his parents for the decision made, and who were of the Jehovah's Witnesses faith. He was given the treatment alternatives which had failed, and the hospital authority approached the court to treat the child by conventional means of a blood transfusion. The court held that *E* had the intelligence to consent to some but not all decisions, which were considered beyond his comprehension of the implications. The judge stated that the child had some concept that he might die but did not understand the manner of his death, the pain and suffering involved, and the distress it would cause to the family. The court subsequently ruled that a blood transfusion should be administered to the child in the best interests of the child. On achieving the age of eighteen years, the patient exercised his rights to self-determination as an adult and subsequently demised.

In *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*,[343] involving a sixteen-year-old girl with anorexia nervosa, the court exercised its jurisdiction over the minor by ordering the transfer against the will of the girl from an adolescent residential unit to a hospital that specialised in eating disorders. Noted, that although the girl possessed sufficient intelligence and understanding for decision-making, the transfer to a specialised hospital was for the girl's best interests to prevent severe injury or death.

In *Re L (Medical Treatment: Gillick Competency)*,[344] the importance of decision-making capacity of children based on '*Gillick* competency' is highlighted. In this case, the court need determine whether *L* had the capacity to understand the nature, purpose, and potential consequences of her decision. It also emphasised that while '*Gillick* competence' empowers children to have more input over their medical decisions, the courts' role was as *parens patriae,* to protect the welfare and best interests of children by overruling and disregarding the rights of refusal of treatment. The case involved a fourteen-year-old Jehovah's Witnesses girl who was a strict adherent of her faith, and who had sustained hot water burns following a seizure and fall in the bathroom. The patient had signed an advanced directive and 'no blood card'. *L* had

342 *Re C (Adult Refusal of Medical Treatment)* (1994) 1 WLR 290.
342 *Re R (A Minor) (Wardship: Consent to Treatment) (*1991) 4 All ER 627.
342 *Re E (A Minor)* 1993 FLR 386-393.
343 *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* (1992) 4 All ER 649.
344 *Re L (Medical Treatment: Gillick Competency)* (1998) 2 FLR 810.

sustained about fifty-four percent burns over her body, of which forty percent was third degree burns. The healthcare professionals advised *L* that she would require surgery and that blood transfusions would be necessary. The anaesthetist advised that due to the potential blood loss, *L's* surgery could not be performed unless she consented to the blood transfusion. The court ruled to administer the blood transfusion on the evidence of the psychiatrist who stated that the patient's strong religious faith did not allow her to deliberate the consequences of her action and therefore would preclude her from formulating a constructive decision.

4.4 The rights of children to self-determination

4.4.1 International instruments

The primacy of best interests of the child is acknowledged in both the CRC and African Charter as discussed in chapter two. Both acknowledge the evolving capacity of children. Articles 5 and 14(2) of the CRC requires the state parties to recognise and respect the responsibilities of parents, extended families or legal guardians to provide direction and guidance in accordance with the evolving capacities of the child.[345] The General Comments of the CRC recognises children's agency in decision-making and for independent decision-making of children.[346] Article 12(1), obliges state parties to assure children who are capable of forming their own view, to express those views freely in all matters concerning them. It is submitted that whilst Article 12 promotes the child's capacity for self-determination and autonomy, it does not provide children with rights to have their decision implemented, whether this applies to consent and refusal of medical treatment.[347] Varadan groups these rights into three broad principles, namely: the enabling principle, the interpretative principle, and the policy principle, which provides for the interpretation of the specific provision of the 'evolving capacities', guiding states on policies broadly empowering children to exercise their rights.[348]

Article 3 of the CRC further recognises the evolving capacities in the child's best interests by placing emphasis on the views of children to be taken into account as the children mature. Article 9(2) of the African Charter, reinforces evolving capacities of children and the role of

345 Article 5 and 14(2) of CRC.
346 General comments 12 and 15 of CRC.
347 P Mahery 'The United Nations Convention on the Rights of the Child: Maintaining its values in International and South African Child Law' in T Boezaart (ed) *Child Law in South Africa* (2009) 309.
348 Cf. H Kruger 'Allowing competent children in South Africa to refuse medical treatment: Lessons from England' (2021) 3 *Stell LR* 421; S Varadan 'The Principle of Evolving Capacities under the UN Convention on the Rights of the Child' (2019) 27 *International Journal of Children's Rights* 308.

state parties to recognise the need for children for independent decision-making with advancing age and maturity.[349] Article 4(2) directs state parties to recognise and protect children who are capable of formulating and communicating their views and the right to be heard directly or through impartial proceeding whether judicial or administrative.[350] The child's right to participation in decision-making with evolving capacities requires a balance between the rights of children to autonomy while affording them the protection from decision based on their relative immaturity.[351]

4.4.2 The South African legislative framework

The Constitution clearly sets out the rights of children.[352] Section 28(2) of the Constitution, clearly reinforces that the best interests of the child are of 'paramount importance'. However, it is also submitted that the rights conferred to children in section 28(2) are not absolute and that these rights must take into consideration other competing rights and are subject to limitation.[353] Although the right to self-determination is not expressively protected in the Bill of Rights, it is submitted that the right to self-determination can be inferred from several fundamental rights in the Bill of Rights. This is elucidated by *Christian Lawyers Association v Minister of Health (Reproductive Health Alliance as Amicus Curiae)*,[354] where the court was tasked to explore the constitutional validity of section 5 of the Choice Act, where this section was challenged on the basis of the violation of the right to life. The court rejected this argument based on the Bill of Rights only being applicable to humans and not the fetus. The court highlighted the provisions of the Bill of Rights and emphasised that the rights afforded to adults also extended to girls under the age of eighteen years of age. It recognised unfair discrimination based on age[355] and recognised fundamental rights to individual self-determination based on the provisions of the Bill of Rights, namely: the right to inherent dignity and to have their inherent dignity respected and protected,[356] the rights to bodily and psychological integrity and the right to security and control over their body inclusive of the rights to make decisions

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349 Article 9(2) of African Charter.
350 Article 4(2) of the African Charter.
351 H Kruger 'Allowing competent children in South Africa to refuse medical treatment: Lessons from England' (2021) 32(3) *Stellenbosch Law R*eview 423.
352 S 28 of the Constitution of the Republic of South Africa, 1996.
353 *S v M (Centre of Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC) in H Kruger 'Protection of children's right to self-determination in South African Law with specific reference to medical treatment and operations' (2018) 21 *PELJ* 18.
354 *Christian Lawyers Association v Minister of Health (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 T.
355 S 9(3) of The Constitution of the Republic of South Africa, 1996.
356 S 10 of The Constitution of the Republic of South Africa, 1996.

concerning reproduction and not to be subjected to medical or scientific experimentation without their informed consent,[357] the rights to privacy[358] and the rights to reproductive health care.[359] Although the Choice Act did not expressly set a capacity requirement, it is submitted that instead of using age, it recognised capacity for consent. This was further emphasised in the *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development,*[360] which dealt with the criminalisation of sexual conduct of children between twelve and sixteen years of age and found that the provisions of the Sexual Offences and Related Matters Act 32 of 2007 constitutionally invalid. The Constitutional Court held that privacy promotes human dignity by protecting an individual's 'sphere of private intimacy and autonomy'. It is also submitted that the right to self-determination can also be derived from the rights to freedom of expression, religion and association.[361] This reinforces the view that children and adolescents who are capable of decision-making, can consent to medical treatment. Additionally, the right to control over one's body presupposes the stance that every individual, including children could consent to medical treatment.[362]

As previously mentioned in chapter two, children have the right to participate in any matter concerning them and their views[363] should be taken cognisance of, provided the best interests of the child remains paramount.[364] Children are entitled to have access to information concerning their health status, treatment[365] and the information provided to them should be relevant and in a format accessible to them.[366] Any major decisions concerning children, mandates any person holding parental responsibilities to give due consideration of the child's age, maturity and stage of development.[367] While the Children's Act does not define medical treatment or surgical operation, it provides for any child above the age of twelve years to consent to medical treatment, provided the child is of sufficient maturity and possesses the

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357 S 12(2) of The Constitution of the Republic of South Africa, 1996.
358 S 14 of The Constitution of the Republic of South Africa, 1996.
359 S 27(3) of The Constitution of the Republic of South Africa, 1996.
360 *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development* 2014 (2) SA 168 CC.
361 Cf. H Kruger 'Allowing competent children in South Africa to refuse medical treatment: Lessons from England' (2021) 32(3) *Stellenbosch Law Review* 426 in I Currie and J De Waal (eds) *Bill of Rights Handbook* 6 (2013) 601.
362 E Durojaya 'The decision-making power of adolescents to refuse medical treatment in South Africa: Lessons from other jurisdictions' (2023) 10 *Acta Judica* 240.
363 S 10 of Children's Act 38 of 2005.
364 S 9 of Children's Act 38 of 2005.
365 S 13(1) (a-e) of Children's Act 38 of 2005.
366 S 13(2) of Children's Act 38 of 2005.
367 S 31(1) of Children's Act 38 of 2005.

mental capacity to understand the benefits, risks and social implications of treatment.[368] A child above the age of twelve years may consent to a surgical treatment provided they have the mental capacity to understand the benefits, risks and other social implications of the treatment and should be duly assisted by the parent or guardian.[369] Both consent to medical and surgical treatment are subject to section 31 of the Children's Act. An important provision in the Children's Act is the role of substitute decision-makers, where the child is not of sufficient age and maturity to understand benefits, risks or social implications of the operation. The superintendent, or the person in charge of the hospital in the absence of the superintendent, may consent to medical treatment or an operation in emergency and life-threatening situations where it is necessary to preserve life or prevent injury or disability.[370] The Minster can provide consent in circumstances where the parent or guardian cannot be traced or is incapable or refuses to provide or assist the child in giving consent. [371] The Minster may also consent to medical treatment or operation if the parent or guardian unreasonably refuses to give consent.[372] The High Court may intervene in providing consent in circumstances where a person mandated to give consent refuses.[373] It is submitted that the terminology 'unreasonably refuses to give consent or assist the child in giving consent', or 'incapable of giving consent or assisting the child in giving consent' is suggestive of the 'difference in meaning of consent and assistance'. The phrase 'duly assisted' is not clearly defined and requires clarification in the Children's Act. 'Duly assisted' can be interpretated as various actions that can be taken by the parent or guardian to supplement a child's decision-making capacity and corresponds to the parental responsibilities of guiding, advising and assisting the child taking cognisance of the child's age, maturity and stage of development which conforms to Article 5 of the CRC.[374]

Consent to surgery or an operation needs to satisfy legislative prerequisites. In instances where a child above twelve years of age consents to treatment, it is mandatory for a written and signed consent by the child, the parent or guardian and completed by the person performing the

368 S 129(2) of Children's Act 38 of 2005.
369 S 129(3) of Children's Act 38 of 2005.
370 S 129(6) of Children's Act 38 of 2005.
371 S 129(7) of Children's Act 38 of 2005.
372 S 129(8) of Children's Act 38 of 2005.
373 S 129(9) of Children's Act 38 of 2005.
374 H Kruger 'The realization of children's rights to participate in selected medical decisions in South Africa' (2018) 135 (1) *SALJ* 95.

operation or a representative of the institution where the operation is to be performed.[375] The healthcare professional is mandated to explain,

> the nature of the problem requiring a surgical operation, the most suitable surgical operation, the risks associated with the surgical operation, the benefits associated with surgical operation, alternative forms of treatment, social implications of the treatment or surgical operation and any other implications or possible consequences of the surgical operation.

The child's acknowledgement and assent to signature confirms a comprehension of the risks and benefits and possible consequences of this surgical operation that have been explained that he or she has been given an opportunity to ask questions about their condition, alternative forms of treatment, and the risks of non-treatment, and possible consequences of the surgical operation. The parents or guardian need to assent in written confirmation of assisting the child in the decision-making process for a surgical operation and that the child is twelve years of age or older, is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the following surgical procedure or operation.

The Children's Act is protective of children above twelve years of age 'who are capable of participating'[376] and expressing their views and are of sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of treatment. It is submitted that children who are below the age of twelve years or above the age of twelve years and who have the capacity to formulate a view but lack maturity and mental capacity for decision-making are not afforded similar protection.[377] Similarly, when read with the National Health Act mandates participation in the decision-making process.[378] While participation is not defined, it could be interpreted as the right to express any views on decision-making.[379] The National Health Act obligates treatment to be instituted with an informed consent[380] and for the user to have knowledge of the benefits, risks, alternatives, and cost implications prior to the treatment to be

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375 *General Regulations Regarding Children* (GN R261 in GG 33076 of 1 April 2010) regulation 54, form 34.
376 S 10 of Children's Act 38 of 2005.
377 Kruger (note 374 above; 96).
378 S 8(1) of National Health Act 61 of 2003.
379 Kruger (note 374 above; 95).
380 S 7(1) of National Health Act 61 of 2023.

instituted.[381] The information provided must be in a language that takes into account the level of literacy.[382]

4.5 The right to refuse treatment

A minor can give consent provided that they achieve sufficient intelligence and maturity to comprehend the treatment proposed. In adults, the legislative framework in South Africa affords adults the rights to refuse treatment. The question arises as to whether the right to consent and refuse treatment is similarly afforded to children. Competency may be limited by the decision being made; whereby a '*Gillick* competent child' may not be able to consent to complicated treatment.[383] The requirement of the child to have the decision-making capacity as an adult would therefore afford the child adult competency. The dilemma therefore arises once competency is determined whether the child's refusal to treatment should be respected regardless of the consequences.[384]

Kruger submits that the legislative framework in South Africa affords the right to refuse treatment of children above twelve years of age.[385] The right to consent to treatment and the corresponding right to refuse treatment is derived from the Constitutional right to bodily and psychological integrity, which is inclusive of the right to security and control over their body.[386] This right is reinforced by the National Health Act,[387] which mandates healthcare professionals to inform users of the right to refuse treatment and explain the implications, risks and obligations of the refusal of treatment. McQuoid-Mason regards this refusal by children as 'informed refusal'.[388] Kruger notes that although the Children's Act does not explicitly afford children the right of refusal, children cannot be subjected to treatment whether medical or surgical without consent. A child of consenting age and maturity cannot be subjected to treatment without consent, and neither can treatment be imposed on them.

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381 S 6(1) of National Health Act 61 of 2003.
382 S 6(2) of National Health Act 61 of 2003.
383 P Trowse 'Refusal of medical treatment- a child prerogative?' (2010*)* 10(2) *QUTLJ* 203.
384 M Buchener-Eveligh 'Is it a competent child's prerogative to refuse medical treatment' (2019) 52 *De Jure* L*aw Journal* 242.
385 H Kruger 'Allowing competent children in South Africa to refuse medical treatment: Lessons from England' (2021) 32(3). *Stellenbosch Law Review* 430.
386 S 12(2) of The Constitution of the Republic of South Africa 1996.
387 S 6(d) of National Health Act 61 of 2003.
388 D McQuoid-Mason 'The National Health Act and refusal of consent to Health Services by Children' (2006) 96 *SAMJ* 530.

Kruger is also of the opinion that this right for refusal of treatment is inferred from the wording of the Children's Act, which authorises the Minister of Social Development to consent to treatment if the child unreasonably refuses to provide consent. This by implication, confers the right to refuse treatment. The legal protection afforded to adults to refuse treatment with risks of deterioration and death, are not the same as afforded to children. The provisions of the Children' Act with determination of maturity by the healthcare professional and the interpretation of 'due assistance' may result in the decision by the child being overruled by the parent and the healthcare professional. Where the decisions of children are considered 'unreasonable', this could be overruled by the Minister.[389] Ultimately, the High Court has the authority in terms of the common law to make decisions in the best interests of the child.[390]

4.6 Conclusion

A failure to understand the information provided to formulate the decision, to retain the information provided, and to utilise the information provided to formulate the decision or communicate the decision verbally or otherwise, would constitute a lack of decision-making capacity in competent adults presumed to have capacity. It is submitted that South African courts have held that capacity includes the ability to comprehend, intellectually and emotionally, the nature and consequences of the act being undertaken and the ability to exercise judgment to decide.[391] Confirming '*Gillick* competence' affords children with decision-making competency as adults. Once competency has been established, the challenge arises as to whether the right to self-determination would supersede the 'principle of sanctity of life'. Legally competent adults' right to self-determination regarding their decisions for medical treatment must be respected regardless of the opinion, beliefs or judgment of healthcare providers rendering the treatment. With children, the determination of competency and the ability to consent to treatment is not based on age alone but by the stage of development of the child towards adulthood and the ability to demonstrate knowledge and understanding. The jurisprudence in the preceding discussion highlights children's rights to self-determination in decision-making based on competence but also reaffirms that the rights are not absolute if decisions are against the child's best interests and can be overruled by the High Court and the Minister of Social Development. Prior to decision-making for medical and surgical treatment,

389 Kruger (note 385 above; 430).

390 D McQuoid-Mason 'Parental refusal of blood transfusion for minor children solely on religious grounds-the doctor's dilemma resolved' (2020) 110 *SAMJ* 29.

391 A E Strode 'Adolescent self-consent to medical interventions in South Africa' (2023) 17(3) *SAJCH* 136.

the level of competency needs to be ascertained. The concerns related to the variable dictionary definitions of medical and surgical treatment have significant impact on children of consenting age for decisions-making. Should blood transfusions be considered as medical treatment, this would consequently confer a child of twelve years of age and above, the autonomy to make decisions provided that the child is of 'sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications'. Should a blood transfusion be considered as a surgical treatment, the child needs to be 'duly assisted,' provided the child is of 'sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation'.[392] The next chapter will conclude in response to the research questions and explore blood transfusions in the context of invasiveness to make recommendations for decision-making of children.

[392] Trowse (note 383 above; 204).

CHAPTER 5: CONCLUSION

5.1 Concluding remarks

Medical treatment and surgery, as discussed in chapter one, are not defined by the Children's Act which has significant implications for consent for children. Van der Westhuizen,[393] noted that that the lack of guidance from the common law on how medical and surgical treatment should be interpreted and suggested that the Children's Act should be revised to provide clarity. The author explored the consent provisions and definitions of medical and dental treatment in various Australian jurisdictions to provide guidance. It was noted that dental treatment was considered separately. Reference was made to a definition of medical treatment in the Guardianship and Administration Act of Victoria[394] that broadly defined medical treatment as inclusive of:

> medical, surgical procedure, operation or examination as well as prophylactic, palliative or rehabilitative treatment performed by or under supervision of a registered practitioner.

Certain procedures were excluded from the definition of medical treatment, such as any procedure that renders a person infertile, procedures carried out for research purposes, termination of pregnancy, non-intrusive examination conducted for diagnostic purposes, first aid treatment and the administration of pharmacological treatment or any other treatment. Van der Westhuizen made references to The Medical Treatment Act of 1998,[395] which defined medical treatment as 'carrying out an operation or administration of a drug or any other medical procedure excluding palliative care'[396] and the Minors (Property and Contracts) Act 60 of 1972[397] in New South Wales, which gives recognition to children above the age of fourteen to give consent.[398] Dental and medical treatment were defined as treatment rendered by a dentist or medical practitioner in the course of the practice of dentistry or medicine or surgery, respectively. Van der Westhuizen proposed that consent requirements for children should be

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393 C Van der Westhuizen 'Medical treatment v surgery: Where does medical treatment end and surgery begin in terms of section 129 of the Children's Act?' (2018) 39(3) *Obiter* 791- 802.
394 S3 of the Guardianship and Administration Act No 58 of 1986.
395 The Medical Treatment Act 41 of 1998.
396 Van der Westhuizen (note 393 above; 799).
397 The Minors (Property and Contracts) Act No 60 of 1972.
398 Van der Westhuizen (note 393 above; 800).

revised to make provisions to formulate criteria for minor and major medical treatment in collaboration with specialists.[399]

The administration of blood and blood products would be lifesaving in the treatment of medical and surgical complications. The National Health Act and Regulations ensure that blood and and blood products are processed and administered in a safe manner.[400] Healthcare professionals intentional or negligent conduct by failure to comply to the minimum requirements, would result in civil or criminal liability and face sanctions by the Health Professional Council of South Africa. The doctrine of informed consent serves as a primary means of protecting the patient's right to control their medical treatment.[401] The doctrine also presupposes the capacity of the patient to make treatment decisions, while taking into consideration the available treatment alternatives, assimilation of the facts, and assessment of their own personal circumstances.

The Constitution guarantees the right to privacy, bodily and psychological integrity, inclusive of the rights to make decisions concerning reproduction, security and control over one's body and not to be subjected to medical or scientific experimentation without an informed consent.[402] The National Health Act, addresses informed consent in a competent patient where no intervention or treatment can be performed without an informed consent. It also sets out the requirements for information disclosure to take cognisance of the literacy level of the patient. This would have significant implications for children of consenting age. The failure of obtaining an informed consent, would result in the failure of protecting an individual's security and control of their body from unwanted physical interference. Therefore, in the absence of an informed consent, an invasive medical intervention would constitute assault and would be actionable in law.[403] This was demonstrated in *Malette v Schulman*,[404] where Malette, a devout Jehovah's Witness, was admitted to hospital with injuries sustained in a motor vehicle accident. Malette was unconscious on arrival to hospital and was in urgent need of a lifesaving blood transfusion. Malette carried the Jehovah's Witnesses card, which explicitly stated her refusal of a blood transfusion based on her religious conviction. Despite the clear directive, Dr Shulman administered a blood transfusion to save her life. The court expressed that a doctor

399 Van der Westhuizen (note 393 above; 802).
400 Chapter 8 National Health Act 61 of 2003.
401 D M McQuoid-Mason & M Dada *A-Z of Medical Law* (2011) 52.
402 S 12 of The Constitution of the Republic of South Africa of 1996.
403 M S Khan 'Failure to obtain informed consent-is it a criminal offence?' (2023) 113(9) *SAMJ* 1362.
404 *Mallette v Schulman* (1990) 67 D.L.R (4th) 321, Carsewell Ont 642, (1990) O.J. No 450.

cannot substitute his or her own judgment for that of a patient when this relates to matters of personal and religious conviction. Malette subsequently sued Dr Shulman for battery. The Appeal Court upheld the trial court finding of 'liability in battery', awarded quantum and reaffirmed the patient's right to autonomy and self-determination would be overriding to all 'countervailing considerations'.[405]

It is submitted that the right to self-determination forms the basis of an informed consent that is inclusive of the right to refuse treatment. A competent adult could consent or refuse treatment at the detriment of serious harm or death. The common law recognises the rights of a legally competent patient of sound mind to withhold or withdraw treatment or make an advance directive of such request.[406] Adult Jehovah's Witnesses patients do not choose the 'right to die but accept non-blood alternatives'. In instances involving an emergency, where time is of the essence, treatment would be permissible provided that the patient is incapable of providing consent, where the patient is unconscious, lacks decision-making capacity, is without legal proxy to provide consent, and where any further delay would result in serious bodily injury or death. In such circumstances, it would be assumed that the reasonable person would probably consent. Therefore, should the doctor proceed with unauthorised treatment in the face of refusal of treatment, this could be criminally or civilly liable, notwithstanding the doctor's belief that his actions were justifiable to save a life.[407] Should the patient lack competency, the National Health Act provides for consent to given by proxy decision-makers. However, should the patient have an advanced directive, this should be taken into consideration for all matters concerning the patient.

The CRC and the African Charter contain significant provisions recognising the rights to self-determination and autonomous decision making of children and the evolving capacity of children. Both recognise the best interests of the child, which is reflected in the Constitution and Children's Act confirming the best interests of the child as being of 'paramount importance,' where any decision concerning children should consider the best interests. Children are afforded the rights to basic health care services, family care, parental care or the appropriate level of care when removed from the family environment, and the right to be protected against maltreatment, neglect, abuse and degradation.[408] Children, like adults, are

405 Ibid.
406 D McQuoid-Mason 'Can children aged 12 years or more refuse lifesaving treatment without consent or assistance from anyone else' (2014) 104(7) *SAMJ* 467.
407 M A Dada & D M McQuoid-Mason *Introduction to Medico-Legal practice* (2001) 16.
408 S 28 of The Constitution of the Republic of South Africa, 1996.

afforded similar fundamental rights to equality and rights, which are not to be discriminated against on numerous listed grounds, including age.[409] Furthermore, children have rights to privacy,[410] dignity,[411] health,[412] life,[413] security, and control over their body and the rights not to be subjected to medical or scientific experiments without an informed consent.[414] While parental rights to parenting are well recognised,[415] these rights are not unlimited, especially if in conflict with fundamental rights and the best interests of children. No decisions can be made based on religious grounds unless there is a suitable alternative to medical or surgical treatment.[416] Jurisprudence has elucidated instances where parental authority and refusal of blood transfusions based on religious beliefs, in Jehovah's Witnesses, can be overruled by the *parens patriae* jurisdiction of the courts if this is against the best interests of the child.

The evolving capacity of the child is recognised in the CRC and African Charter. Both confer recognition to children with advancing age and maturity to self-determination and autonomous decision-making capacity. This is reinforced in the Children's Act, which states that once a child is of:

> sufficient age, maturity, and stage of development as to be able to participate in any matter concerning that child, has the right to participate in an appropriate way and the views expressed by the child must be given due consideration.[417]

Therefore, parental authority would diminish as the child matures and the capacity of the child grows.

The Children's Act acknowledges the principles of the '*Gillick* competent child's' right to decision-making in a child above the age of twelve years, providing that the child has the maturity to understand the 'benefits, risks, social and other implications of the treatment'.[418] '*Gillick* competency' recognises that once a child achieves sufficient maturity and intelligence to understand fully what is proposed, the ability to weigh the options and nature of treatment proposed, then the child would have the capacity for decision-making. The more complex,

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409 S 9 of The Constitution of the Republic of South Africa, 1996.
410 S 14 of The Constitution of the Republic of South Africa, 1996.
411 S 19 of The Constitution of the Republic of South Africa, 1996.
412 S 27 of The Constitution of the Republic of South Africa, 1996.
413 S 11 of The Constitution of the Republic of South Africa, 1996.
414 S 12 of The Constitution of the Republic of South Africa, 1996.
415 S 18 of Children's Act 38 of 2005.
416 S 129(10) of Children's Act 38 of 2005.
417 S 10 of Children's Act 38 of 2005.
418 S 129 of Children's Act 38 of 2005.

serious, and long-term consequences of risk would require a greater degree of maturity and capacity. The circumstances under which the child makes those decisions are relevant and must be free of coercion, fear, stress or pain, and not made while taking medication, which may influence the decision-making capacity. The best interest standard is applicable in all instances and should take into consideration the child's age, maturity and stage of development, gender, background, emotional and physical security, intellectual, emotional, cultural development, any disabilities, chronic illness, need for protection and the parental attitude and capacity. [419]

While the Children's Act stipulates that a child of twelve-years of age and above can consent to medical treatment and be 'duly assisted' for a surgical treatment, it does not specifically address children's rights for refusal of treatment. The Children's Act, nevertheless, mandates the Minster of Social Development to intervene when the refusal of consent is considered unreasonable.[420] Kruger submits that there are no provisions made for unreasonable consent to treatment, which is considered as unjustifiable, and that once a 'child reaches adult capacity, the need for the best interests criterion should fall away'. Kruger is of the opinion that the outcomes approach adopted by the English courts where the child's decisions could be overridden if this is contrary to the best interests of the child, should be in favour of 'minor's reasoning for reaching the decision'.[421] Additionally, it is submitted that best interests are a 'fine line', that is only understood by the '*Gillick* competent child' requiring treatment and once a competent child knows what is in their best interests, they may have good reasons to make those decisions.[422] McQuoid-Mason submits that children should also be able to refuse treatment based on the provisions of the National Health Act, which places a responsibility on healthcare professionals to explain the implications, risks, and obligations of such refusal. This 'informed refusal' entails providing the child of legal capacity with information based on the level of literacy and understanding of such refusal.[423]

The rights of children to consent to medical treatment is reinforced by CRC, African Charter, and national laws, that takes into consideration the decision-making capacity. It is submitted that the determination of lack of capacity cannot be ascertained by age, appearance, intelligence, level of education or any condition or aspects of behaviour that would result in

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419 S 7 of Children's Act 38 of 2005.
420 S 129(7) of Children's Act 38 of 2005.
421 H Kruger 'Allowing competent children in South Africa to refuse medical treatment: Lessons from England' (2021) 32(3) *Stellenbosch Law Review* 432.
422 P Trowse 'Refusal of medical treatment – A Childs Prerogative' (2010) 10(2) *QUTLJ* 209.
423 D McQuoid-Mason 'National health Act and refusal of consent to health services by children' (2006) 96(6) *SAMJ* 530.

'unjustified assumptions' of capacity.[424] The High Court may intervene in any decision that is contrary to the best interests of the child. Furthermore, no medical or surgical decisions based on religious can by refused or withheld, unless it is shown that there is a suitable alternative.[425]

It is conspicuous that the drafters of the Children's Act did not provide a clear delineation between medical and surgical treatment, a deficiency that carries substantial implications for the legal framework governing children's capacity to provide informed consent. This mini-dissertation aims to contribute to the ongoing debate by addressing this deficiency and exploring potential recommendations for new terminology regarding the classification and understanding of blood transfusions.

5.1.1 Is there room for new terminology?

The variable dictionary definitions of medical treatment and surgery have generated extensive indecision on how certain procedures and interventions should be perceived. Current medical technology has advanced to such an extent that it necessitates a re-evaluation of the concepts of how treatments should be viewed. Therefore, to provide clarifications would require insight into the treatment modalities. The invasiveness of treatment remains 'morally important' due to the 'implicit and explicit value judgements' that involves invasive and non-invasive treatment.[426] Often, the classification of medical intervention is based on the 'The Standard Account' where a medical intervention is invasive 'if and only if it involves either breaking the skin by incision or insertion of an object into the body'.[427] However, while 'The Standard Account' is commonly used for consideration of invasiveness of the treatment, it does not incorporate all the scenarios involved in medical intervention.

5.1.2 The concept of invasive treatment and blood transfusions

In re Fetus Brown,[428] Darlene Brown, who was thirty-four weeks pregnant, sustained complications post cystoscopy and removal of urethral mass resulting in significant blood loss. Due to her Jehovah's Witnesses faith and beliefs, Brown refused the blood transfusions that were essential to save her life. The Trial Court appointed a *guardian ad litem* to protect the

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424 S C Chima 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa' (2013) 14(1) *BMC Medical Ethics* 14.

425 S 129(10) of Children's Act 38 of 2005.

426 G De Marco … et al 'What makes a medical intervention invasive' (2024) 50 *J Med Ethics* 226.

427 Ibid.

428 *In re Fetus Brown* 689 NE 2d 397.

interest of the fetus and the mother. The guardian authorised the blood transfusion, Brown recovered and gave birth to a healthy child. The Appellate Court of Illinois ruled that the Trial Court erred in exerting its authority for Brown to undergo treatment and reasoned that the state's interest in preserving the life of the mother and fetus cannot override a pregnant women's competent refusal of recommended invasive medical treatment. The court ruled that the state may not overrule a 'competent pregnant woman's treatment decisions including refusal of recommended invasive medical procedures to potentially save the life of the fetus'. The court further rejected the contention that blood transfusions were non-invasive and risk free and ruled that a blood transfusion is 'an invasive medical procedure that interrupts a competent adult's bodily integrity' and therefore should be regarded as an operation rather than treatment'.

To administer blood or blood products would entail intravenous access requiring insertion of a peripheral or central intravenous line. The placement of peripheral lines is considered as the most invasive procedure performed in acute healthcare settings with more than one billion lines being used annually worldwide. [429] [430] [431] The Royal Brisbane and Women's Hospital considers the peripheral intravenous cannulation as an:

> invasive procedure which increases the patient's risk of local and or systemic complications which have the potential to result in patient morbidity and mortality, increased healthcare costs and length of stay.[432]

The definitions of invasive medical treatment are conspicuous in the literature with the similarities. Invasive medical intervention may be considered as 'a diagnostic or therapeutic procedure in which the skin is broken (e.g. with a surgical blade or syringe) or an instrument is introduced into a body cavity'.[433] It may be regarded as 'one in which the body is invaded, or entered by a needle, tube, device, or scope',[434] or 'involving entry into the living body as

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429 W Zingg … et al 'Best practice in the use of peripheral venous catheters: A scoping review and expert consensus' (2023) 5 *Infection Prevention Practice* 1.

430 G Beechan & G Tackling 'Peripheral Line Placement' (2023) *Stat Pearls*, NCBI Bookshelf, available at https://www.ncbi.nlm.nih.gov/books/NBK539795/, accessed 6 October 2024.

431 C Thomas … et al 'Peripheral intravenous cannula insertion and use in tertiary hospital emergency department: A cross-sectional study' (2020) 23(3) *Australasian Emergency Care* 166.

432 'Peripheral Intravenous Cannulation, Venepuncture and Infusions- Adult and Paediatrics Version 6' (2015), available at https://az.research.umich.edu/medschool/glossary/invasive-procedures, accessed 6 October 2024.

433 'Invasive' Medline Plus, available at https://medlineplus.gov/ency/article/002384.htm, accessed 6 October 2024.

434 'Invasive Procedures' Medical School, University of Michigan, available at https://az.research.umich.edu/medschool/glossary/invasive-procedures, accessed 6 October 2024.

by incision or by insertion of an instrument',[435] or 'involves operating on a patient examining the inside of their body',[436] or as 'medical treatment involving cutting the skin or putting something into one of the spaces in the body',[437] or 'as a medical treatment involving entry into the body, commonly through an incision or insertion of instruments often posing certain risks,'[438] or 'as any medical procedure that involves entering the body, typically through a cut or insertion of instruments for therapeutic and diagnostic purposes'.[439] The significance of these definitions correlate with the continuous evolution of medical intervention where newer forms of treatment and intervention may be alternative to surgical intervention.

De Marco et al, argue that invasiveness may differ from the 'Standard Account' depending on three key characteristics. Firstly, the degree of invasiveness, where the intervention is considered invasive or non-invasive. Commonly encountered with medical intervention is the concept of minimally invasive procedures, such as minimally invasive surgery or minimally invasive blood glucose monitoring. Secondly, whether the intervention is regarded as invasive would be based on the circumstances and the 'salient alternatives' in a particular context. The nature of the alternatives could also be considered as invasive. De Marco et al describe scenarios such as tube insertion for gynaecological and gastrointestinal procedure, which may be regarded as minimally invasive and where the alternative would be surgery. To further elucidate this concept, is endotracheal tube insertion for mechanical ventilation where the alternative would be non-invasive mask ventilation. The taking of blood samples for glucose monitoring would be considered invasive as opposed to the alternatives such as finger prick, subcutaneous micro sensors that would be considered non-invasive. Thirdly, medical intervention could be considered as invasive in a non-physical manner especially when the intervention may involve 'highly sensitive parts of a person's mental life', such as psychotherapy which may be considered as emotionally or psychologically invasive or 'lifestyle invasive' such as repeat appointments disrupting patient daily routines.[440]

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435 'Invasive' Mirriam-Webster, available at https://www.merriam-webster.com/dictionary/invasive, accessed 6 October 2024.

436 'Invasive' Collins Dictionary, available at https://www.collinsdictionary.com/dictionary/english/invasive, accessed 6 October 2024.

437 'Invasive' Cambridge Dictionary, at https://dictionary.cambridge.org/dictionary/english/invasive, accessed 6 October 2024.

438 Mosby's Medical dictionary (9th ed), Elsevier Health Sciences (2013) 1044.

439 Stedman's Medical Dictionary (28th ed), Lippincott Willaims and Wilkins (2006) 912.

440 De Marco et al…. 'What makes a medical intervention invasive' (2024) 50 *J Med Ethics* 228.

Whitely et al[441] conducted an online study searching for the definitions of non-invasive, non-surgical, minimally invasive, minimal access, pinhole, and keyhole and proposed a classification to cover all medical procedures. This consisted of two components, namely, access (A) and invasiveness (I) which was termed as the AI classification to stratify certain procedures. The degree of access considered criteria such as whether there was no access (A), access through natural orifice (B), or penetration of an epithelial surface (C). The criteria for invasiveness were based on whether there was no invasive procedure (1), surface damage (2), insertion of a needle less than twenty gauge (3), whether there was an insertion of cannula greater than twenty-one gauge but not a surgical trocar (4) or insertion of surgical trocars or small incisions (5) and incisions (6). They submit that that their proposals would apply to all medical procedures and would be understood by both patients and healthcare providers and would clarify the confusion surrounding non-invasive, minimally invasive and open surgery.

Table 1: Access and Invasiveness Classification[442]

Access	1st term	Invasiveness	2nd term
A - None	-	1 - None	Non-invasive
		2 - Surface damage	Superficial ablation
B - Natural orifice	Internal	3 - Needle up to 21G	Pinhole
		4 - Cannula >21G but not a surgical trocar	Minimally invasive
C - Penetrating an epithelial surface (internal or external)	Penetrating	5 - Trocars and small incisions - single or multiple <1 cm - single or multiple	Minimal access (or 'Keyhole')
		6 - Incision or incisions ≥1 cm	Open

The above table demonstrates the classification based on access and invasiveness determined by degree of surface damage and use of instrumentation.

441 Whitley … et al 'The access and invasiveness-based classification of medical procedures to clarify non-invasive from different forms of minimally invasive and open surgery' (2024) 20(3) *Journal of Minimal Access Surgery* 301.

442 Ibid.

Table 2: AI classification based on description of procedure[443]

AI classification	Description (1st term, 2nd term)	Examples
A1	Non-invasive	Ultrasound, HIFU; radiofrequency skin tightening without microneedles, laser or intense pulsed light skin rejuvenation
A2	Superficial ablation	Laser hair removal, laser hair removal, laser skin resurfacing, laser ablation of skin lesions, electrolysis hair removal
B1	Internal non-invasive	Gastroscopy, sigmoidoscopy, transvaginal ultrasound, transrectal ultrasound, bronchoscopy
B2	Internal superficial ablation	Colposcopy cervical ablation, endoscopic laser ablation of mucosal lesions or blood vessels, gastroscopy with biopsy, colonoscopy with biopsy
B3	Internal pinhole	Endoscopic sclerotherapy of bleeding vessels, endoscopic needle biopsy
B4	Internal minimally invasive	Endoscopic biopsy with forceps
B	Internal minimal access (or 'Internal Keyhole')	NOTES
C2	Penetrating superficial ablation	Shave biopsy, split skin graft, electrosurgery, laser fractionated skin tightening, radiofrequency skin tightening with microneedles
C3	Penetrating pinhole	Sclerotherapy for veins, botulinum toxin injections, dermal fillers injected through a needle of 21G or smaller
C4	Penetrating minimally invasive	Thread lifts, dermal fillers injected through a cannula, endovenous varicose vein surgery, central line
C5	Penetrating minimal access (or 'Keyhole')	Laparoscopic surgery, thoracoscopic surgery, arthroscopy
C6	Penetrating open	Laparotomy, thoracotomy, craniotomy

HIFU: High-intensity focused ultrasound, NOTES: Natural orifice transluminal endoscopic surgery, AI: Access and invasiveness

The above table demonstrates two parts of the AI classification based on the nomenclature used and how each is described.

Cousins et al[444] in a study analysing 3946 papers over a decade, considered a preliminary definition based on existing definitions that were continuously updated and applied to all articles in their analysis. The definition considered three basic criteria, based on the method of access to the body, instrumentation, and requirement for operator skill. In their final analysis, Cousins et al proposed a definition of an invasive procedure, whereby,

> An invasive procedure is one where purposeful or deliberate access to the body is gained via an incision, percutaneous puncture, where instrumentation is used in addition to puncture needle, or instrumentation via a natural orifice. It begins when entry to the body is gained and ends when the instrument is removed and or the skin is closed. Invasive procedures are performed by trained healthcare professionals using instruments, which include, but are not limited to endoscopies, catheters, scalpels, scissors, devices and tubes. Where invasive procedure also involves the administration of a medicinal product, these could be categorised as being part of an invasive procedure when operator skill is required for its administration within the body that is when an internal action is performed to administer the product or the product is administered to a targeted anatomical area.[445]

443 Ibid.

444 Cousin … et al 'What is an invasive procedure? A definition to inform study design, evidence synthesis and research tracking' (2019) 9 *BMJ* 1.

445 Ibid at 2.

With the preceding discussion, it is evident that how procedures would be classified could assist in providing clarity and could be utilised and applied for in informing policy.

5.2. Recommendation

It is submitted that a '*Gillick* competent child' is not vulnerable and 'not in need of protection with respect to proposed medical decisions'. It is not regarded as lesser form of competence and once the child achieves competency, the child with evolving capacity is afforded the privilege to make fully informed medical decisions. The competency and ability of the child to consent or refuse treatment must be demonstrated and not presumed. This must entail intensive discourse with involvement of parents and healthcare professionals.[446]

The dilemma of blood transfusions being medical or surgical treatment is clearly demonstrated by the variable definitions of medical and surgical treatment. This is further compounded by the chasm in the Children's Act on the explicitness of medical treatment and surgery. As discussed, the rights of children to make medical decisions are well recognised, provided they reach the age threshold and show sufficient maturity to understand the risk, benefits, social and other implications provided that the decisions are considered reasonable and in the best interests of the child. Regarding surgical treatment, children of twelve years of age or above would need to be assisted by parents or those holding parental responsibilities. The requirements are that the child needs to consent to treatment and must acknowledge in writing a knowledge and understanding of the nature, consequences, risks and benefits of surgery or operation. The healthcare provider is obligated and must assent in writing confirmation that the child is over twelve years of age or older, is of sufficient maturity, and has the mental capacity to understand the risks, benefits, social and other implications of surgery or operation.

Intravenous access is essential for the administration of a blood transfusion, which may be achieved by peripheral or central venous access. Therefore, if the insertion of the intravenous line is considered an invasive procedure, and jurisprudence suggests that administration of a blood transfusion is a 'risky invasive procedure', it is logically inferred that the administration of a blood transfusion should be regarded as an invasive procedure. The definition proposed by Cousin et al[447] appears to be more suitable, germane and enlightening in this regard.

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446 Trowse (note 422 above; 211).
447 Cousin … et al (note 444 above; 2).

Therefore, consistent with the recognition of the evolving capacity of the child and right to self-determination, it would be judicious to amend Section 129(3) of the Children's Act to include invasive treatment. This would not only be applicable to blood transfusions but would be inclusive of any procedure considered as invasive and could potentially apply to dental procedures.

Section 129 (3) should be amended to read as follows:

> A child may consent to the performance of a surgical operation or invasive procedure on him or her or his or her child if
>
> *(a)* the child is over the age of 12 years; and
>
> *(b)* the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation or invasive procedure; and
>
> *(c)* the child is duly assisted by his or her parent or guardian.

Furthermore, amendments to the Children's Act should be made to include invasive procedures in subsections 129(5) to 129(10) alongside medical treatment and surgical operations, to enhance clarity and strengthen the protection of children's rights and best interests.

Compliance with legislation is mandatory when administering blood and related products safely. These requirements apply equally to both adults and children. The doctrine of informed consent serves as the primary means of protecting patients' rights to control their treatment. For competent adults, the right to self-determination forms the basis of informed consent, including the right to refuse treatment even at the risk of serious harm or death. This principle, however, differs for children if against their best interests.

As children age and mature, their evolving capacities become more significant and relevant, including their rights to autonomy. However, the primary focus in medical decision-making for children is to protect them from their 'immaturity of judgment'. Determining '*Gillick* competence' is not based solely on age alone but on the child's developmental stage and ability to demonstrate knowledge and understanding. The right to self-determination in children is not absolute, especially when it is not in their best interests.

While parents or those holding parental responsibilities have the constitutional right to freedom of religion and to guide their children's religious choices, a child's freedom of religion is influenced by their level of maturity and the religious direction provided by their parents. For

society to function normally, there should be consistency, conformity to, and respect for the law, particularly fundamental human rights. There is no automatic right for exemption from legislative and common law requirements in favour of religious practices. Where the religious rights of parents come into conflict with the fundamental rights of children, the rights of children take precedence over the parents' religious beliefs. Jurisprudence, particularly in the context of Jehovah's Witnesses and blood transfusions, has demonstrated that the best interest standards for children should apply in all instances regardless of the decisions made by parents or children. The rights of children to self-determination differ from those of adults especially if decisions have detrimental consequences for children.

The ambiguity surrounding whether blood transfusion constitute medical treatment or surgery, combined with the lack of clarity in the Children's Act, presents significant challenges in securing informed consent for minors. This uncertainty is particularly critical in life-saving interventions involving children, where religious beliefs may conflict with medical recommendations. Without clear legal guidance, healthcare providers, parents and guardians face complex ethical and legal dilemmas that could affect a child's best interests. Addressing this issue through precise legal definitions and structured frameworks is essential for safeguarding children's rights, ensuring ethical medical decision-making and providing much needed clarity for both medical professionals and parents. While this mini-dissertation focuses on Jehovah's Witness's and blood transfusions, the recommendations extend to other invasive procedures, including dental treatments, ultimately contributing to greater legal clarity and consistency.

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ANNEXURE: ETHICS APPROVAL



Dr Nitinkumar Mohan Ghila (953059479)
School Of Law
Howard College

Dear Dr Nitinkumar Mohan Ghila,

Original application number: 00026099
Project title: Blood transfusions: medical treatment or operation. Challenges encountered when balancing autonomy and religious beliefs with best interest standards

Exemption from Ethics Review

In response to your application received on 27 September 2024 , your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW.**

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

In case you have further queries, please quote the above reference number.

PLEASE NOTE:
Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours sincerely,

[redacted]

Mr Matthew Blain Kimble
pp Academic Leader Research
School Of Law