

**Defining “sufficient maturity”: providing clarity on Section 129 of the
Children’s Act.**

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DECLARATION

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Abstract

It becomes increasingly clear that when one deals with a child that one is not only dealing with the child but the entities that are responsible for the child as well. One, however, becomes aware that the intention of these entities, be they bona or mala fide, may not always translate into an outcome that is inherently beneficial to the child who is the subject of medical intervention.

This concern was noted by the Legislature and was addressed as best they deemed fit with the inclusion of additional rights for children in section 129 of the Children's Act. These rights allowed the child a certain level of participation in their health care needs. However, these rights were attached to "sufficient maturity", a phrase that finds no clarity in the Children's Act and has been seemingly left to the discretion of the Health Care Provider that finds him/herself in the position of treating a minor.

This thesis aims to provide some certainty as what the content of sufficient maturity is and perhaps more importantly how Health Care Providers can give effect to the rights of children. Furthermore, the thesis provides the psychological backdrop for evaluating children and for making certain positive assumptions as to the agency of the child in need of health care. These assumptions are developed and used in tempering the ethical, be they western or ubuntu in nature, and legal landscapes in which Health Care Providers and children find themselves.

The product of this thesis is a framework that aims to assist Health Care Providers in their interactions with the child, their parents, caregivers, guardians, or community in circumstances where the nature of the interactions is almost as crucial as the help sought by the child.

Abstrak

Dit word toenemend duidelik dat wanneer 'n mens te doen het met 'n kind, 'n mens nie net die hantering van die kind, maar ook die entiteite wat verantwoordelik is vir die kind in ag moet neem. Hierdie entiteite is onder andere die kind se ouers, voogde en of gemeenskap. Verder is dit soms duidelik dat die bedoelings van hierdie entiteite, of dit nou bona of mala fide is, nie altyd die inherent voordeligste uitkoms vir die kind onderworpe aan mediese ingryping weergee nie.

Hierdie kommer is deur die Wetgewer opgemerk en so bes moontlik aangespreek met die insluiting van addisionele regte vir kinders soos vervat in artikel 129 van die Kinderwet. Hierdie regte besorg aan die kind 'n sekere vlak van deelname in hul gesondheidsorg behoeftes. Hierdie regte is egter gekoppel aan die begrip voldoende volwassenheid ("sufficient maturity"), 'n begrip wat geen duidelikheid in die Kinderwet vind nie. Die interpretasie van die begrip word skynbaar aan die diskresie van die gesondheidsorgverskaffer oorgelaat, wat hom of haarself in die posisie van die behandeling van 'n minderjarige bevind.

Hierdie tesis het ten doel om meer duidelikheid aan die inhoud van die begrip voldoende volwassenheid te verleen en dalk nog belangriker hoe gesondheidsorgverskaffers hierdie regte van kinders kan toepas. Verder bied die tesis 'n sielkundige benadering tot die evaluering van kinders met die behoefte aan gesondheidsorg in die bepaling van voldoende volwassenheid. Hierdie benadering is tesame met die etiese ontwikkel, hetsy westers of ubuntu in benadering as ook die wetlike landskappe waarin gesondheidsorgverskaffers en kinders hulself bevind

Die uitset van hierdie tesis is 'n raamwerk wat daarop gemik is om gesondheidsorgverskaffers in hul interaksie met die kind, hul ouers, hul voogde en of gemeenskap te help in hul interpretasie met begrip rakende die belangrikheid tussen die hulp soos deur die kind vereis asook die omstandighede en aard van die behandeling soos benodig deur die kind.

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CHAPTER ONE

Introduction

When considering the interplay between bioethics and the South African legal system it is worth noting the comments of Fabricious J in *Stransham-Ford v Minister of Justice and Correctional Services and Others* 2015 (4) SA 50 (GP) (4 May 2015), where the judge, in open court, noted that in accordance with Earl Warren, that “in a civilised life, law floats in a sea of ethics”. Furthermore, it is accepted, albeit to varying degrees, that law developed as a result of philosophy and, arguably has no distinction other than it being more strictly adhered to. It is this interplay in a very specific area that forms the focus of this thesis and more importantly informs and guides the manner in which the writer has arrived at a suitable definition of sufficient maturity.

1.1. Problem Statement

According to Ganya et al (2016) there are numerous concerns surrounding the notion of sufficient maturity and more importantly the seemingly arbitrary ages attached thereto. It is noted that absent a definition to assist in the evaluation of sufficient maturity that one fails before one starts and that as a result one is left making little progress, and that as most physicians have voiced, the concept is simply ignored and decisions are deferred to more clearly defined decision makers. In light of these and other concerns the thesis will seek to illuminate a possible approach to assist in cases that deal with consent and sufficient maturity.

Section 129 of the Children’s Act requires that a child may consent to medical treatment if the child is 12 years of age and if the child has sufficient maturity. The present view, derived from the literature, is that medical treatment may be best understood as examinations of a non-evasive nature, appropriate treatments and the dispensing of medication. Given the content of what is to follow it is suggested that the reason for the interplay between the requirements is to afford children the opportunity to participate meaningfully in decisions related to their health. This participation is however, still subject to the child being able to understand the implications of their status and decisions and this capacity is recognised through the implementation of

certain parameters and assumptions. Thus, the content of medical treatment will have an interesting effect on the determination of sufficient maturity due to the potential for increasing complexity in both the explanation and risk of the medical treatment identified and engaged upon. The thesis will consider the content of sufficient maturity as it pertains to children older than 12 years of age as set out in the Children's Act.

The thesis aims to provide a workable definition for "sufficient maturity", in light of legislative silence and bioethical ambiguity by building upon the definition provided by Ganya et al (2016:5), namely that "[a] child has sufficient maturity to consent to medical treatment insofar as he or she can independently demonstrate (or be facilitated either by aids or a helper as far as it is practically possible in that given setting to possess) the commensurate wherewithal required to assume responsibility for that specific decision".

This adaption will see the definition developed to include more than just the application of medication and will consider the developmental models put forward by the likes of Erikson, Freud and Piaget in order to determine if a child does indeed possess the necessary competency to be considered sufficiently mature to provide informed consent.

Accordingly, once the thesis has laid the platform with respect to sufficient maturity it will then seek to adapt the models to better work in the context of South African healthcare. The above will then be amended to better assist health care providers in South African contexts.

Part of this tailoring to the South African context will involve addressing the concern that one may need to change the terminology as the constructs used by established schools could in some instances be considered unacceptable within the traditional communities in which they will need to be implemented, in no small part due to the perceived conflict that may arise when one considers notions such as autonomy within communitarian communities. For instance, present schools of thought have terms such as "maturity" which inherently attaches to the individual and which, as cautioned by Rakotsoane and van Niekerk (2017:252) has proven "problematic when applied in

some non-Western communities because they are perceived as strongly rooted in Western culture”.

There will then also need to be clarity as to the relationship between the individual and the community. To this end it is worth considering the following two analogies in respect of this inter play. The first is that the individual forms an individual node within an intricate web of relationships with the emphasis resting on the fact that duties are only extended in so far as there is a relationship between the parties, and that should the strand disconnect between two nodes that the web of relationships suffers. This analogy is similar to that proffered by Rakotsoane and van Niekerk (2017:255) in that the “reality out there is perceived as a single integrated totality of cause and effect in which different components (including humans) hang harmoniously together like threads of a spider’s web until one member (usually a human agent) does something to disturb the harmony”.

A possible second analogy is that the community forms the medium through which the individual members are permitted to interact. Thus, the medium allows the individuals to act and the individuals give the medium legibility through their continued actions. Both analogies serve to highlight that neither the individual nor the community is more important than the other and that without the one the other would cease to exist. However, in light of the above analogies it is clear that there is inherently an attachment to the individual, the communal and the interaction between the two.

Thus, every interaction/decision or consideration must involve a cognitive element, both identifiable and measurable, that is developed from entrance into the community.¹ The thesis will then conclude with the appropriate definition and application within the context of South African healthcare.

¹ Tutu (2004:25) notes that a “person is a person through other persons. None of us comes into the world fully formed. We would not know how to think, or walk, or speak, or behave as human beings unless we learned it from other human beings. We need other human beings in order to be human”. Moloketi (2009:243) and Tutu (2004:25-26) note that the word Ubuntu is derived from a Nguni (isiZulu) aphorism: Umuntu Ngumuntu Ngabantu, which may be translated as meaning “a person is a person because of or through others”, and can thus be described as the capacity in an African culture to express compassion, reciprocity, dignity, humanity and mutuality in the interests of building and maintaining communities with justice and mutual caring.

1.2. Summary

As alluded to above the focus will be on the development of the definition put forward by Ganya et al (2016). The thesis will seek to define the individual components in greater clarity as well as provide support for the individual considerations making up the definition.

What follows below is an evaluation of the relevant literature available concerning the above issue that the present material seeks to address. The review has predominantly focused on the content of “sufficient maturity” as well as the application thereof in the field of bioethics as it intertwines with the South African legal landscape. In respect of the former, academia was sourced in the form of journals as well as other literary contributions. In the latter, precedent was utilised in conjunction with statute and various regulatory devices.

Chapter 2 will provide a summarised view into the factors that form the adolescent mind, being the age under consideration in section 129 and the subject of this thesis, and will provide a basis into the competency and capacity of adolescent decision makers. The summary will begin by providing the assumptions, in understanding the capacity of the adolescent mind, and guidelines that one is to utilise when determining if the adolescent mind is capable of being considered sufficiently mature.

In the subsequent chapters, the author will seek to give an introduction into the history of the ethical and legal principles that will inform the later chapters. To this extent, Chapter 3 will consider the creation and importance of instruments such as the Nuremberg Code and the Belmont Report. The particular summary will conclude by noting the development of these instruments into the four principles of bioethics.

The thesis will seek to mould the definition and its underpinnings in line with the theory of Ubuntu. The thesis will first provide a brief summary of what Ubuntu is and more importantly why it is of use in the South African context. Thereafter, the material will consider the aforementioned definition and see how it can be reworked to best serve the communities that subscribe to the notions of Ubuntu and communitarianism.

In respect of the legal landscape, Chapter 4 will consider international as well as regional and national legal instruments. The legal considerations will conclude with an evaluation of the Health Professions Council of South Africa's guides on treatment and what standards they hold practitioners to, as well as their legal standing. As noted the summary is to provide a foundation upon which the definition can be developed and amended.

In Chapter 5 the thesis will evaluate the considerations formulated by the various sources and voices within the field. The chapter will commence by setting out what constitutes informed consent and more importantly what the shortcomings are that the definition will need to overcome in order to be beneficial and implementable. Once this has been concluded the material will provide support for the theory of being able to take responsibility by considering the work completed in respect of child development. This will be done with the aim of supporting the theory of responsibility as well as providing support to the notion that children are intelligent enough to make the decision and that one needs to evaluate the process rather than the outcome.

Furthermore, the material will seek to provide reasoning for why the term medical treatment should be expanded from merely the non-evasive use on medication to include evasive procedures that may be considered to be simple or common place.

The thesis will conclude in Chapter 6 with a Framework to assist with the interaction of minors and those tasked with their health.

CHAPTER TWO

A necessary exploration and affirmation of the development of persons in adolescence

“Young people do not only begin to look more like adults, they also start to think more like adults.” – Louw & Louw (2014:324)

2.1. Introduction

The aim of this section is to assist in changing preconceived notions of what competencies and capacities children, and specifically in the context of adolescents being the age under consideration in section 129 of the Children’s Act, possess. The reason for this, per Ganya et al (2016:01), is that “[a] child considered in this view is not regarded as a full person. This implies that decisions concerning the child...are discussed and determined by the community”.

Thus, in an attempt to assist in the content below, the chapter will consider only aspects of cognitive and social development within the adolescent. What follows will assist in determining if a child does indeed possess the requisite capacity to be considered sufficiently mature as submitted by Ganya et al (2016:03) in that:

“When [the child] obtains decisional capacity of such degree that affords [the child] the kind of engagement necessary in decision-making comparable to that of fully developed persons, viz adults, we will comprehend that as what is inferred by the Act as ‘sufficient maturity’.”

At the onset this chapter relies on the contributions made by a variety of authors in the respective field and that as a result this chapter will merely seek to draw one’s attention to the actual development stage of the minor in order to show the necessary decision-making that will constitute sufficient maturity.

The chapter will begin by considering the views held of children through the ages before considering the various development issues and the accompanying theories. The chapter will conclude with a more focused analysis on the period known as adolescence, which covers the age under consideration being 12 to 18, and how the

theories can be interpreted to show that minors do indeed have or are capable of having sufficient maturity.

2.2. Children through the Ages

It is evident from the fact that many cultures indulged in practices that caused harm to children from infanticide to genital mutilation and murder of youths that children have not been considered highly through the ages. From this archaic point of view, the child moved to the Middle Ages in which children were by no means in any better position.²

The progression thereafter, although an improvement for children did not leave them any better off especially when considering the views held by British philosopher John Locke who said that children are a blank slate and that what ultimately creates children is their experiences, which creates their personality.³

However, the plight of the child was not only a common place in Western civilisation. If one considers sub-Saharan Africa, although records were not kept, events such as intertribal warfare, raids, slavery and trafficking were common practice which in no way assisted children throughout the 15th, 16th and 17th centuries.⁴ Although slavery was abolished at the end of the 19th century, living conditions, arguably, are close if not worse for a considerable amount of children around the world.⁵ At the beginning of the 20th century not much had changed for children, in fact in most cultures and customs children are to this day considered to be property or subject to the will of others. In South Africa the Court is the upper Guardian of children, thus meaning that children can be removed from situations that do not benefit them.

It is clear that children have not had, and continue not to have, the most favourable position in Africa. Child Soldiers International notes that the use of child soldiers in armed conflict may be as high as one hundred thousand⁶. Furthermore, education, a

² Louw & Louw (2014:05).

³ Louw & Louw (2014:05).

⁴ Louw & Louw (2014:05).

⁵ Louw & Louw (2014:05).

⁶ <https://www.child-soldiers.org/FAQs/how-many-children-are-used-for-military-purposes-worldwide> (accessed on the 28th of May 2017)

basic right, is still withheld from many a child in Africa⁷ and this lack of education has created a lustful youth that finds themselves either on the verge of indignity or on the side of political manipulation.

Louw & Louw (2014:06) remind us that during Apartheid there were gross inequalities, and that many of these inequalities have not been addressed to the level that one would expect in a post democratic society. After the advent of democracy South Africa subsequently became a member to international instruments that assisted in the protection, nurturing and development of children. This will be looked at in greater detail in the Chapter 4. This was further bolstered by an increase in civic education and civic organisations.

With all this development it is still problematic that one would need to reemphasise the point that Ganya et al (2016:03) put forward in that “if we are to truly recognise the moral equality of children with adults we ought to grant that capacity of whatever kind need not be the arbitrating principle on the conferring of rights on children”.

2.3. Development Stages

Louw & Louw (2014:08) explain that there are different stages to a child's development comprising the prenatal stage; the neonatal stage; early childhood; middle childhood; and adolescence. For the purpose of this thesis children are anyone under the age of 18 years of age, being an age confirmed in law and to a large extent by the respective literature. However, the references made to children, unless specified otherwise, will refer to children above the age of 12 in accordance with the requirements of the Children's Act.

Although special attention should be given to physical development, cognitive development, personality development, and social development within these various stages the primary focus will be on cognitive and social development to better develop

⁷ Regrettably, South Africa continues to see failures in the delivery of education to many children. <http://greatertubatsenews.co.za/2017/05/25/limpopo-learners-still-experiencing-textbook-crisis/> (accessed on the 28th of May 2017)

the necessary aspects of the definition. It should not be forgotten that all development noted herein below will be within a social context.

2.4. Developmental issues

Now it should be noted that there are a variety of factors that may affect the aforementioned development.

The first developmental issue, according to Louw & Louw (2014:10), to be considered involves the question of nature versus nurture, with nature referring to biological detriments such as genetic, neurological and hormonal factors, and nature referring to environmental factors such as social and the physical environment. Louw & Louw (2014:11) explain that the reasons that this debate has continued is firstly, that it is heavily interwoven with arguments that are not strictly scientific being both political and religious belief systems. Secondly, the issue encompasses such a wide variety of behaviours that it is relatively easy to find an example that will support either view. Lastly, that the cause of specific behaviours is often very difficult to prove.

The next developmental issue is that of continuity or discontinuity in which it is distinguished that the core question is whether human development is a continuous or a discontinuous process.⁸ This continuity-discontinuity issue has also resulted in psychologists asking if later behaviour can be predicted from early characteristics of the child continuing to late adult life. It is this concept of continuous development that has resulted in the adoption of assumptions regarding the development of children and accordingly their capacities developing as opposed to the capacities simply appearing at the age of majority.

The next issue concerns passive or active involvement, with Louw & Louw (2014:13) pointing out that the issue here is whether children have no part in their development and therefore are at the mercy of their environment or whether they can play an active role in their own development. It is noteworthy that most psychologists agree that although the influence of the environment cannot be denied children also take an

⁸ Louw & Louw (2014:12).

active part in their own involvement. The review concludes by recognising that most psychologists acknowledge that the unique way in which children cognitively and emotionally interpret and process their experiences has a significant influence on their development.

The following issue, according to Louw & Louw (2014:13), is that of universality or cultural context where one needs to ask - do all children in the world follow universal pathways or are there clear differences along cultural lines. As the horizons of psychology started to expand many researchers started to realise that the cultural context in which a person develops cannot be discarded. More recently numerous psychological studies have been conducted confirming that cultural factors can play an important role in a child's development.

Louw & Louw (2014:14) caution that paths of development in one culture may be very different from paths in other cultures, and that another important cultural influence is the role of parental practices in the socialisation of their children.

According to Louw & Louw (2014:15), not only is psychological development affected by culture but biology can be influenced by cultural viewpoints as well. However, one should take care and should not overemphasise the role of culture on development. In this regard Louw & Louw (2014:15) suggest that: firstly, it should be taken into account that the differences within one culture are larger than the differences within another culture: and secondly, culture is not a static process. They conclude by noting that the Golden Rule, being that of averages, should always be remembered and that every individual is unique even within a sub- cultural context.

In light of the above it is evident that there are a variety of influencing factors when evaluating the development of a child. What has become apparent though is that the development is influenced by environmental factors as well as biological considerations. Thus, it seems appropriate at this stage to note that development is influenced by both biology and culture and that it is an ongoing process within a fluid world.

2.5. Theories of development

According to Louw & Louw (2014:16) “[t]heories are essential for understanding children's development because they provide the why of development. In child development, a theory is an organised set of ideas that is designed to explain and make predictions about development”.

To this end the thesis will now consider various developmental perspectives that will impact upon social as well as cognitive development. It cannot, however, be disregarded that the other factors do form a larger web of interactions that will be dealt with accordingly. As mentioned above what follows is a brief summary of the relevant theories, with a more in-depth analysis being applied in the section dealing with adolescence.

2.5.1. The Biological Perspective

Louw & Louw (2014:17-18) begin the discussion with the notion that behaviour is primarily determined by biological factors, and that there are various theories that assist, notably: the maturational theory, the ethological theory, and the evolutionary theory. Louw & Louw (2014:19) continue this explanation in that once “[a]ppplied to child development, evolutionary developmental psychology highlights the adaptive value of children's behaviour at different points in development. This approach therefore forces us to remember that children's behaviour often has ‘evolved over the past several million years to handle the problems faced by our...ancestors’”.

There have been scientific adaptations housed in the fields of⁹: neuropsychology, which focuses on the nervous system and the brain; behavioural genetics, which is the study of the role of genetic factors in behaviour; and psycho-endocrinology, which focuses on the relationship between behaviour and the endocrine system. These adaptations have allowed for the realisation that one's biology will influence your social and cognitive development. This will have to be considered by participants in the exchange of healthcare.

⁹ Louw & Louw (2014:20).

2.5.2. The Psychodynamic Perspective

According to Louw & Louw (2014:20) this perspective “largely explores the influence of unconscious psychological motives, such as drives or urges on behaviour, represents the oldest psychiatric/psychological perspective on development of children”. One should not consider this perspective in isolation from the previous perspective or those to follow as they all should provide for a more holistic approach to the evaluation of a child’s development.

2.5.2.1. Freud’s Psychosexual Theory

As mentioned previously the minor will only be inferred to have sufficient maturity if certain developmental milestones have been achieved, some of which were brought forward by Freud (1953-1974). Louw & Louw (2014:20) set out that one of the theories that has been used, and built upon as noted in the content still to follow, holds that development is largely determined by how well people resolve the unconscious conflicts that they face at different ages. It is argued that personality, which is the outcome of the process, includes three primary components, all of which emerge at different ages, namely: the id; the ego; and the superego.

Freud (1953-1974) began by identifying that the “id is a reservoir of primitive instincts and drives. The id is present at birth and demands immediate gratification of bodily needs and wants...The ego is the practical, rational components of personality. It begins to emerge during the first year of life, as infants learn that they cannot always have what they want... the superego is the ‘moral agent’ in the child’s personality. It emerges during the preschool years as children begin to internalise adult standards of right and wrong.”¹⁰

The theory is, arguably, at this stage, of benefit in determining the milestones that have been achieved by the minor and if they could be considered to be sufficiently mature. However, the theory has faced considerable critique, notably being that his views of development were based on adults recalling the past not from observing

¹⁰ Louw & Louw (2014:20-21).

children. Louw & Louw (2014:22), however, suggest that most psychoanalysts accept that all life stages are important, and that psychological growth continues throughout life. This means that trauma, at any stage of one's life, can have a significant effect on development. A further critique was that Freud overemphasised the role of sexual feelings in the development of the child while ignoring other important areas such as cognitive development.

Although the theory shows that development is continuous it also shows that there are factors such as cognitive development which cannot be disregarded and it is these factors that will better be able to assist us in determining if the minor is sufficiently mature. As cautioned at the start of this section one should never deal with the theories in isolation as this would not allow one to appreciate the continuous development aspects housed in each and how these better assist in understanding minors and their capacities.

2.5.2.2. Erikson's Psychosocial Theory

In *Childhood and Society*¹¹, Erikson illustrated his psychosocial theory on development which consists of a sequence of stages each defined by unique crisis or challenge.¹² Erikson also went beyond the traditional psychosexual phases that ended with the "genital" phase.¹³

Cherry (2017) highlights Erikson's (1950) eight stages of psychosocial development being that of: basic trust versus mistrust (birth to 1 year); autonomy versus shame and doubt (1 to 3 years); initiative versus guilt (3 to 6 years); industry versus inferiority (6 years to adolescence); identity versus identity confusion (adolescence); intimacy versus isolation (young adulthood); generativity versus stagnation (middle adulthood); and integrity versus despair (late adulthood). By the time a person reaches adolescence they are considered to have overcome the first half of the challenges. These stages assist in dealing with the world and in framing how to regulate the subsequent interactions.

¹¹ Erikson (1950).

¹² Louw & Louw (2014:22).

¹³ Lidz (1974:14).

Roazen (2012:6) highlights the importance of one's place in history and how that was achieved by referring to Erikson's conclusion "that any clinical concept of human nature demands historical self-awareness". This conclusion allows us to consider cultural and historical influences on development and to better evaluate a child's development or perceived deficit.

2.5.3. The Learning Theory Perspective

The early learning theories were put together by Mr John Watson, and were largely influenced by the work of Ivan Pavlov.¹⁴ The theories described the process as being that of classical conditioning and suggested that the same was present in the human experience. As a result of critique levelled against him, the theory was expanded to include that "learning determines what children will be; experience was all that mattered in determining the course of development".¹⁵

The theory was further developed to propose the process of operant conditioning, with the basic principle being that "if a child's behaviour is rewarded it is more likely to be repeated, but if the behaviours are met with negative reaction, it is less likely to recur".¹⁶ This theory shows that development is a process and, as with all processes that one will be able to determine the minor's stage within the process. This is of particular importance as it will allow the evaluator to determine with a certain degree of confidence if the minor is sufficiently mature or not.

2.5.3.1. The Social Cognitive Theory

At this stage it is best that the thesis focus on the development of factors which fall in line with the subject matter.

The theory notes that "children learn much by simply watching those around them, which is known as imitation, modelling or observational learning".¹⁷ To this extent, Louw & Louw (2014:25) refer to the work of Albert Bandura in which he refined his

¹⁴ Louw & Louw (2014:23).

¹⁵ Watson (1924:82).

¹⁶ Louw & Louw (2014:24).

¹⁷ Louw & Louw (2014:24).

theory “by placing more emphasis on children's ability to decide which behaviour to model”, and that this “decision is influenced by children's own expectations of what the consequences of imitating the model’s behaviour will be, the child's own personal standards and value system and how powerful and dynamic the model is”.¹⁸

The criticism with respect to this is that there is a “general view that the supporters of the theories have placed too much emphasis on environmental determinants” and that “inadequate attention is paid to developmental changes”¹⁹. Louw & Louw (2014:25) conclude that the final critique is that “the role of cultural factors, especially regarding child-rearing practices, is not always taken into account”.

The critiques allow for great insight as the various cultures present within South Africa come with a variety of practices that need to be given due consideration when evaluating the child in question.

2.5.4. The Cognitive Developmental Perspective

This perspective focuses on how children think and how their thinking changes over time.²⁰ It is further of import that the various developmental stages, contained herein below by the prospective contributors, will assist in shedding light on the cognitive capabilities of children.

2.5.4.1. Piaget’s Theory on Cognitive Development

According to Piaget (1932:1) “[c]hildren’s games constitute the most admirable social institutions”. Lidz (1974:17) notes that Piaget sought to “uncover the psychological foundations of knowing”.

¹⁸ Chegg reaffirms this noting that at the core the theory highlights that people learn through watching, while the Boston University notes that Albert Bandura began in the 1960's and that the theory “posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior”.

¹⁹ Louw & Louw (2014:25).

²⁰ Louw & Louw (2014:25).

According to Louw & Louw (2014:25) Jean Piaget (1932), believed that “children naturally try to make sense of their world” and that, as described by Cherry (2014)²¹, children not only want to understand the workings of their world but play an active role in the learning process. To achieve this “children act like scientists in creating theories about their physical and social worlds; they try to weave all that they know about objects and people into a complete theory. Children's theories are tested daily by experience because their theories lead them to expect certain things to happen. As with real scientific theories, when the predicted events do occur, a child's belief in his/her theory grows stronger. When the predicted events do not occur, the child must revise his or her theory”.²²

Piaget (1932) uses the example of children playing marbles and going from the game to appreciating the environment it is played in as well as the value of the various marbles. Thus, a child is considered to have sufficient maturity when the child has the capacity not only to consider the facts at hand but has the capacity to test that outcome and to appreciate it. A child would thus require a cognitive capacity as well as the necessary framework and information to populate it with.

Piaget (1932) “believed that at a few critical points in development, children realise their theories have basic flaws. When this happens, they revise their theories radically. These changes are so fundamental that the revised theory is, in many aspects, brand-new theory. These radical changes imply that children go through four distinct changes in cognitive development. Each stage represents a fundamental change in how children understand and organise their environment and each stage is characterised by more sophisticated types of reasoning”.²³

It is thus important to mention that although the child is still developing it would be incorrect to assume that the child lacks the capacities necessary to participate meaningfully in the decision and that the child is not competent.

²¹ Cherry (2017) Piaget's (1936) Theory: The 4 Stages of Cognitive Development: Background and Key Concepts of Piaget's Theory <https://www.verywell.com/piagets-stages-of-cognitive-development-2795457>

²² Louw & Louw (2014:25-26).

²³ Louw & Louw (2014:26) and Cherry (2017).

Cherry (2017) in agreement with Louw & Louw (2014:26) sets out Piaget's (1936) four stages of cognitive development, namely: Sensorimotor (birth to 2 years); Preoperational (2 to 6 years); Concrete Operational (7 to 11 years); and Formal Operational (12 and older). Of import here is that the first three stages go toward showing how much development has actually occurred whereas the fourth stage indicates that children are well equipped to be informed and to know the outcomes as "children come to understand the world by using schemes, which may be described as a psychological template (structure, framework or plan) to organising encounters and which is based on prior experience and memory. That is, schemes are mental categories of related events, objects and knowledge."²⁴

Piaget (1932) gave the cognitive development of children special interest and noted the following interrelated principles and processes that he claimed exerted a great influence on cognitive development, namely:

"Firstly, organisation, which is the tendency of cognitive processes to become not only more complex, but also more systematic and coherent... Secondly, adaptation which means that as children gain new experiences they have to deal with information that seems to be in conflict with what they already know... Assimilation is the tendency to interpret new experiences in terms of an existing scheme... Accommodation takes place [when new information needs to be dealt with]... This new information forces [the child] to develop another cognitive scheme... Piaget calls this process of constant striving for a stable balance or equilibrium between assimilation and accommodation, equilibration."²⁵

Thus, children are clearly capable of utilising the required information in their schemes, provided a scheme exists in this case being one of health and longevity.²⁶ This theory allows us to assume that children have the capacity to form processes to assist them in understanding information and creating a useable outcome.

²⁴ Louw & Louw (2014:26).

²⁵ Louw & Louw (2014:27).

²⁶ Lidz (1974:17) notes that the child "cannot utilize experiences that his cognitive schema are not yet ready to assimilate".

2.5.4.2. The Information Processing Theory

This theory has great similarities with the present information age and Louw & Louw (2014:27) note that “[m]ental hardware refers to cognitive structures, including different memories where information is stored. Mental software includes organised sets of cognitive processes that allow children to complete specific tasks”. Information-processing theorists “assume that the memory system is made up of multiple components” being the sensory memory, short-term memory and the long-term memory. Like modern computers the older children and adolescents have better hardware and software than younger children.²⁷

Thus, the more developed a child becomes the more sophisticated their thinking processes. “Piaget explains this change in terms of more sophisticated theories that children create: information-processing psychologists attribute it to more sophisticated mental hardware mental software.”²⁸

Once again it would seem that the theory supports progressive improvement in children. However, the question still remains regarding how developed the child is.

2.5.5. The Contextual Perspective

It is here that the thesis begins the dive into the exact effect of social and cultural interactions in that “[a]ll these people and institutions fit together to form a person’s culture – the knowledge, attitudes and behaviour associated with a group of people. A culture provides the context in which a child develops and thus is a source of many important influences on development throughout childhood and adolescence... it is important to investigate the ways in which culture influences the development process.”²⁹

²⁷ Louw & Louw (2014:28).

²⁸ Louw & Louw (2014:28).

²⁹ Louw & Louw (2014:28).

2.5.5.1. Vygotsky's Socio-Cultural Theory

Louw & Louw (2014:29) confirm that Vygotsky “believed that because a fundamental aim of all societies to is to enable children to acquire essential cultural values and skills, every aspect of a child's development should be considered against this backdrop.” This meant that “a child's learning of new skills is guided by an adult or older child, who models and structures the learning experience. Such learning is best achieved in what he called a zone of proximal development [which] refers to tasks which are too difficult for a child to do alone, but which he or she can manage with the help of an adult.”³⁰

Thus, the child develops to integrate into his or society and this is guided by members of that society. Which is why one cannot ignore the importance of societal rules and structures on the development of a child and their deference to authority figures – a deference that may extend beyond adolescence into adulthood and which will accordingly require greater awareness on the part of the Health Care Provider.

2.5.5.2. Bronfenbrenner's Ecological Theory

The contextual view suggests that there are various interrelated systems in which a child develops.³¹ Louw & Louw (2014:29) refer to the work of Bronfenbrenner (1979,1995) which states that this development begins with the microsystem, encompassed by the mesosystem, which lies within the exosystem, and ultimately housed in the macrosystem. Bronfenbrenner (1979, 1995) believed that the “child's environment does not remain static. In fact, it constantly changes, not only regarding the child's social development (e.g. death of a parent, divorce, relocation, school entry), but also regarding the physiological changes related to the child's developmental process”³². Bronfenbrenner called this the chronosystem, as all of these interactions are affected by time and change from youth to adulthood.

³⁰ Louw & Louw (2014:29).

³¹ Louw & Louw (2014:29).

³² Louw & Louw (2014:30).

According to this theory all interactions fall within a wide sphere which encompasses various influences over the course of various lifetimes. Once again one is reminded of the analogies in the introduction where it is noted that individuals are linked to their environments and the other individuals therein. In this view the intersecting points may be so numerous that it may appear that the individuals form the very medium they interact in and with.

2.5.5.3. Super and Harkness' Developmental Niche

A developmental niche is proposed, which refers to the “integration between the child, with his or her specific temperamental and psychological disposition, age and gender, and the various elements in the child's culturally structured environment”³³. According to Louw & Louw (2014:31):

“The first component includes the physical and social environments of the child's daily life, such as the construction of the family, caregivers, size and type of living space, type of toys and learning material and health status of the child. The second component refers to the childcare and childrearing practices applied in a particular culture, such as emphasis on formal scholastic education or informal learning, independence or dependence training, feeding and sleeping practices, play and work patterns, and initiation rites. The third component refers to the psychological characteristics of the caregivers, such as educational practices, value systems, cultural beliefs, and expectations that they have of the child.”

All of these components are great sources of influence on the child's development and show an understanding of the complexities of everyday South African life. It should never be forgotten that South Africa is a country that is rich in cultural diversity and that it is this very diversity that will have a profound impact on the development of minors. This development will stem not only from their own familial and household cultures but how these cultures are interpreted by the child in light of exposure to other cultures. Sufficient maturity is inferred when a child is deemed to have the necessary decision-making skills comparable to that of an adult and that all of the aforementioned factors will no doubt have played a part in the shaping of a child's maturity.

³³ Super and Harkness (1986; 1994; 2002).

2.5.6. The African Perspective

Consideration will now be given to the African Perspective in light of all of these Western approaches for the simple reason that the aim of this thesis is to better allow the development, integration and acknowledgement with in the South Africa's legal framework as well as its socio-cultural spheres. Ganya et al (2016:02) best define this need as African communitarianism emphasises “sociality of persons albeit not refuting the significance of other dimensions of maturity such as the emotionality of the deciding subject in decision-making”.

According to Louw & Louw (2014:32) the “traditional African worldview is based on a holistic perspective of humans and the universe; therefore, human behaviour can be understood only in terms of the greater whole of which the individual is a part”, and that “the community plays a central role. Behaviour is guided by values such as cooperation, interdependence and communal responsibility, and is respected and is represented by the term ubuntu.”³⁴

Louw & Louw (2014:32) point out that human development is regarded as social ontogenesis “because it is situated within the ecological and social environments in which it takes place”. They further describe the human lifespan and life cycle as comprising of three phases of selfhood namely: spiritual selfhood, beginning with “conception, or perhaps earlier, as a reincarnation of an ancestral spirit” and ending with the newborn's umbilical stump falling off and being incorporated into the living community. The second phase is that of social selfhood which “begins at birth, but more specifically after the naming ceremony, and ends with death”³⁵. In the last phase of ancestral selfhood which “follows the biological death of the person, and incorporation into the spiritual selfhood follows with ritual initiations. Ancestors continued to influence people in their daily lives”.³⁶

³⁴ Louw & Louw (2014:32).

³⁵ Louw & Louw (2014:33).

³⁶ Louw & Louw (2014:33).

However, to gain a better understanding of the view held of children in the African context one need only look at the South African Child Guide³⁷ in which it is recorded that children continue to be found in the most vulnerable groups and that this vulnerability comes, predominantly, from the positions that society places them in or fails to help them escape.

It is this web of influence that has been described by Rakotsoane and van Niekerk (2017:255-6) and that has been expanded upon by persons such as former President Thabo Mbeki in his address to parliament “I am an African. I owe my being to the hills and the valleys, the mountains and the glades, the rivers, the deserts, the trees, the flowers, the seas and the ever changing seasons that define the face of our native land.”

Thus, one can see that the uniqueness of the African perspective can have a great impact, and unfortunately increase the chasm between other perspectives and itself. To this end the African perspective should be continuously kept in mind when evaluating the theories and how they potentially influence the development of children.

2.5.7. Conclusion

It is clear to see that a vast amount of effort has been expended in not only defining but also in evaluating a child’s development. It is irrefutable that children develop and that all that is required now is to determine if the development at any particular stage would constitute sufficient maturity.

The remainder of this chapter will discuss what capacities and competencies adolescent children exhibit and how these can then be utilised in determining whether or not the child is indeed competent and capable of making a decision concerning their treatment.

³⁷ South African Child Gauge 2016, Delany A, Jehoma S & Lake L (eds) 2016, Children’s Institute, University of Cape Town
http://www.ci.uct.ac.za/sites/default/files/image_tool/images/367/Child_Gauge/2006/Book_Child_Gauge_2016_lowres.pdf

2.6. A consideration of Adolescence

From what has been introduced in the beginning of this chapter it is evident that by the time a child reaches adolescence, starting at approximately age 10 but as noted 12 for purposes of legal requirements, they are indeed capable of a degree of competency. In light of this it would seem that the question then becomes the level at which this competency exists so that one can determine if sufficient maturity is then present.

What follows herein below aims to dispose of archaic notions regarding children's competencies in that adolescents lack the necessary competency to consent. We should instead utilise the literature as a platform, to inform how to interpret an adolescent's actions, circumstances and development in an effort to reach a conclusion as to whether the adolescent in question possesses the necessary degree of competency, to be able to take responsibility for their actions and by extension is sufficiently mature enough, as noted in Ganya et al (2016:05):

“A child has sufficient maturity to consent to medical treatment insofar as he or she can independently demonstrate (or be facilitated either by aids or a helper as far as is practically possible in that given setting to possess) the commensurate wherewithal required to assume responsibility for that specific decision.”

2.6.1.1. What is adolescence?

It is generally accepted that adolescence constitutes the bridging period between childhood and adulthood, and that although it has not always been regarded as a distinct period of the lifespan, that in most Western societies formal schooling played a large role in determining that period.³⁸ Initially there were biological boundaries put in place as “adolescence as a separate development stage begins, varies from 11 to 13 years, while the age at which it ends is between 17 and 21 years”.³⁹

³⁸ Louw & Louw (2014:303).

³⁹ Louw & Louw (2014:303-304).

According to Louw & Louw (2014:304) as a result of these variances “it would be more acceptable to demarcate the adolescent developmental stage according to specific physical and psychological developmental characteristics and socio-cultural norms, rather than on chronological age.” It is suggested that this is the most beneficial way of proceeding, one need simply consider the case of South Africa and its cultural diversity to agree, as even the legal criteria are ambiguous and similarly not a good indication of the period of adolescence.⁴⁰ With the amendments to the Age of Majority Act, which reduced the age of majority from 21 to 18, one no longer required parental intervention, shy of emancipation, for a large portion of one’s life.

The thesis adopts the view of Louw & Louw (2015:304) that adolescence generally spans from approximately 12 to 18 years of age⁴¹. It must be noted that this should not be seen as limiting any evaluation of a child younger than the age of 12 years, but that for purposes of the thesis 12 to 18 years of age meets the legislative requirements.

2.6.1.2. Adolescence and Physical Development

Physical development will affect the social and cognitive development and thus it is worth considering how it will do so. It is accepted that adolescence is generally characterised by a certain degree of physical development including both extensive physical growth and the development of sexual maturity.

It goes without saying that a great many things happen during this physical development. The first event is that of the adolescent growth spurt, with girls beginning between the ages of 10 to 13 years and ending at approximately 16 years or later, while boys tend to begin at age 12 to 15 years and end at about 18 years or later.⁴²

It is detailed that this is as a result of averages and that children should still be evaluated on a case by case basis, and that:

⁴⁰ Louw & Louw (2014:303).

⁴¹ Ginsburg and Opper (1988:5) note that Piaget’s final stage begins roughly at age 12 and is concluded during adolescence. Once again it is clear that adolescence is not clearly set out and agreed upon by all.

⁴² Louw & Louw (2014:306).

“as mentioned before, the uniqueness of each individual should be taken into account. While some 12- to 13-year-old adolescents may already have the mature body of an adult, other adolescents of the same age may still have the childlike bodies of 10-year-olds. As with all developmental differences, these differences could be attributed to the complex interaction between genetic and environmental factors.”⁴³

The next factor to consider is that of sexual maturation, which described by Louw & Louw (2014:306) is “generally known as puberty, [and] is one of the most dramatic events in human development”, which seems to be happening at a much earlier age within both male and female adolescents⁴⁴ due in no small part to environmental factors, e.g. nutrition, stress and physical exercise, may influence the onset of puberty⁴⁵.

Louw & Louw (2014:307) point out that “[a]lthough many cultures regard the appearance of the menarche as a sign that the girl is now a ‘woman’...most girls start ovulating on a regular basis only about one year after the menarche”. Furthermore, with regards to cultural concerns the authors note that:

“[m]any national and international organisations and governments are currently speaking out strongly against female circumcision. In South Africa, female circumcision at any age is illegal. In fact, it is punishable by imprisonment for three months to life. It is difficult to illegalise traditional customs, however.”⁴⁶

In respect of sexual maturation in boys it seems that this follows a period of one to two years after that of girls and comes with its own set of cultural concerns and regulations. Whereas female genital mutilation is deemed to be serious in nature, male circumcision is only recently becoming equally clouded in controversy as:

“the main reason why male circumcision during adolescence is surrounded by controversy is that traditional procedures have led to many cases of permanent mutilation, the amputation of the penis, infections, haemorrhage, gangrene, and

⁴³ Louw & Louw (2014:306).

⁴⁴ Louw & Louw (2014:306-307).

⁴⁵ Louw & Louw (2014:307).

⁴⁶ Louw & Louw (2014:308).

even death. However, according to tradition, the fact that several initiates die during these rights is not viewed as unusual.⁴⁷

Fortunately, one need only consider the ongoing advances in modern medicine and it would seem that this horror will at least be mitigated to some extent.

It is this cultural influence on something as natural as the development of the biology of an adolescent that needs to be considered in the overall cognitive and social development. The fact remains, however, that no country can allow its children to die or be mutilated for the sake of tradition, acts that are prohibited in South Africa.

The psychological effects that accompany this development within both boys and girls, can never be understated, and Louw & Louw (2014:311) caution that “boys who mature earlier generally have certain characteristics in common” and that these include things such as better body image and higher self-esteem and that because of their strength and size they generally do better in physical activities, however, they are generally prematurely exposed to alcohol, drugs and sex as a result.

Louw & Louw (2014:311) suggest that boys who mature late are generally seen as less attractive and less well-balanced, which results in them being more tense and anxious. These boys also seem to experience more feelings of guilt, inferiority, depression and rejection.

However, the reverse may be true for girls as Louw & Louw (2014:311) explain that girls who mature later are usually perceived as physically attractive, lively and sociable and are generally more popular than those who mature earlier. Girls who reach physical maturity earlier are often attracted to older boys but that they are not always emotionally mature for the intimacies associated with their physical appearance. They are in a marginal social position because they do not fit into the older group or within the group populated by their peers.⁴⁸

⁴⁷ Louw & Louw (2014:309).

⁴⁸ Louw & Louw (2014:311).

Louw & Louw (2014:311) explain that problems surrounding early maturation do not occur universally and that in the African context there are no indications that early maturation is a disadvantage, as early maturation could be an advantage for these girls as they obtain prestige and respect.

The knowledge passed down to adolescents is lamentably inadequate and that as a result of this lack of information one finds prevailing problems, such as the use of or rather the failure to utilise contraceptives.

With this in mind it is perhaps also best to discuss the prevalence of teenage pregnancies within South Africa, as according to Mudhovozi, Ramarumo & Sodi (2012) in South Africa 30% of young women have already given birth by the age of 19 and that according to the Department of Basic Education (2013) in 2011, 51 000 learners attending school had given birth. Teenage pregnancy “is usually the result of high-risk sexual behaviour, poor parental control, family disintegration, inadequate sexuality education, a tendency not to use contraceptives and a general decline in the importance society places on sex as a value norm”.⁴⁹

Although this increase in adolescent pregnancies is a global phenomenon it is especially so in developing countries such as South Africa, where the problem is taking on critical proportions. Researchers have attributed the following as being large contributing factors towards this increase: Firstly, family disorganisation; secondly, rapid urbanisation and westernisation; thirdly, poor socio-economic situations, low educational status and the low social status of women; thirdly, certain family and social practices; and lastly, poor sexual communication between parents and adolescents.⁵⁰

It cannot be ignored that all of this comes with concerns of a legal nature, such as sex between adolescents, and other persons, and the capacity to care for the child conceived as a result of those interactions. Along with these instances one sees increased health concerns, as well as society trying to rectify the matter by, inter alia, imposing marriage as a solution.

⁴⁹ Louw & Louw (2014:318).

⁵⁰ Louw & Louw (2014:319-320).

Now that consideration with regard to the impact that physical development has on a child has been noted the following section will consider more closely the effects of cognitive development, which has been suggested as being largely influenced by the degree of industrialisation of one's country.⁵¹ One is cautioned against failing to be mindful of these considerations when interacting with adolescents.

2.6.1.3. Adolescence and Cognitive Development

According to Louw & Louw (2014:324) “[b]rain development during adolescence largely concerns refinement, and therefore the advancement of existing capabilities”, a statement that reaffirms that adolescents do have the capacity to participate meaningfully in the decision-making process and thus being inferred to have sufficient maturity.

Theories of cognitive development all go toward assisting one with interpreting an adolescent's behaviour, circumstances, and stage of development. This is important when considering if they are indeed capable of accepting responsibility and being sufficiently mature in providing informed consent.

2.6.1.3.1. The Constructive Perspective

Louw & Louw (2014:324) introduce this perspective which “assumes that individuals must continually interpret or make sense of all experiences – whether deciphering printed words, listening to a conversation or recognising a familiar face”, and that:

“children around the ages of 11 or 12 enter the formal operation stage of cognitive development. This is the last stage of cognitive development and extends into adulthood. During this stage, children develop the capacity for abstract, scientific thinking. Instead of thinking only about real things and actual occurrences as younger children do, adolescents are able to think about possible occurrences.”⁵²

⁵¹ Louw & Louw (2014:324).

⁵² Louw & Louw (2014:325).

Louw & Louw (2014:325) detail the following characteristics of a person with formal operational thinking. Firstly, one finds hypothetico-deductive reasoning which refers to adolescents having the cognitive ability to develop alternative ways to solve a problem. The formal operational thinker is able to reason from the general to the specific in that when faced with a problem “they begin with a general hypothesis or theory of all possible factors that may affect the outcome and come to a conclusion about what might happen”.⁵³ They then test these hypotheses which is precisely what is required when engaging with a child concerning their ability to understand the diagnosis proffered as well as the treatment at hand and the consequences of acquiescing to or refusing treatment.

Thus, adolescents are capable of applying scientific reasoning, which further enables adolescents to plan for future as well as adopting the viewpoint of the adversary, without necessarily believing it.⁵⁴ A child would possess sufficient maturity as they would have the capacity to extract what is given to them in terms of a diagnosis and to then, through asking of questions and receiving of information and building hypotheses, are then able to test it.

The second characteristic, according to Louw & Louw (2014:326), is that of propositional thinking, which notes that the formal operational thinker can evaluate the logic of verbal statements without the need to refer to real-world circumstances:

“Reality is the foundation of concrete operational thinking. Formal operational thinkers on the other hand, understand that reality is not the only possibility. They can envision alternative realities and examine their consequences. They use hypothetical reasoning to probe the implications of fundamental change in physical or biological laws.”

The third characteristic is that of combinatorial analysis, which is the ability to organise various possible combinations inherent in a problem and this “means that the adolescent analyses all the possible combinations of variables (factors) making sure

⁵³ Louw & Louw (2014:325).

⁵⁴ Louw & Louw (2014:325).

that all possible variables inherent in a problem, will be investigated. Concrete operational thinkers test variables haphazardly, by trial and error.”⁵⁵

The last characteristic is that of relativistic thinking, which states that “[t]o the concrete thinker, absolute right answers exist for everything and are known by an authority - this is called realism. The formal operational thinker recognises the subjective construction of knowledge and the possibility of differences in the interpretation of the same facts.”⁵⁶

In conclusion with Newman & Newman (2012) “[e]ach one has implications for how adolescents approach interpersonal relationships and the formulation of personal plans, as well as for how they analyse scientific and mathematical information” and that to this extent the authors note that: first, adolescents are able to manipulate mentally more than two categories of variables at the same time; secondly, they are able to think about changes that come with time; thirdly, adolescents are able to hypothesise about a logical sequence of possible events; fourthly, they are able to anticipate the consequences of their actions; fifthly, they are able to detect the logical consistency or inconsistency in a set of statements; and lastly, adolescents can think in a relativistic way about themselves, other individuals, and about their world.⁵⁷

The potential is present with the capacity for decision-making merely being refined in children as they progress to the relevant stage, which allows for the interaction with children in their decision-making enterprises.

2.6.1.3.2. The Information-Processing View

This theory tries to break down human thinking into separate components such as capacities for attention, processing, storing and retrieving information and in support of this Louw and Louw (2014:328) suggest that the cognitive changes in adolescents are refinements of existing abilities rather than the emergence of new ones and therefore this would support the notion that it is a progressive development. Thus, the

⁵⁵ Louw & Louw (2014:326).

⁵⁶ Louw & Louw (2014:326).

⁵⁷ Louw & Louw (2014:327).

capacity exists, but the only way this capacity can be nurtured and realised is if adolescents are given an opportunity to participate in decisions and thereby develop same.

Louw and Louw (2014:328) suggest that adolescent attentional abilities are better adapted to the ever-changing demands of the tasks at hand as the processing of information in terms of speed, capacity and automaticity are increased and improved upon. Furthermore, the knowledge base, encoding, storing and retrieving of information, also show that:

“adolescents are better than younger children are at recognising which features of a problem are most important. They are also able to attend to more features of a problem at the same time and to organise information more systematically. This allows them greater flexibility of thought and enables them to shift their attention from one aspect of a problem to another, rather than being stuck in outworn strategies. Therefore, memory strategies become more effective, improving storage, representation and the retrieval of information.”⁵⁸

Lastly, the theory suggests that in terms of metacognition and cognitive self-regulation that the former’s capacities expand leading to new insights into effective strategies for acquiring information and solving problems while the latter improves yielding better moment by moment monitoring, evaluation and self-directing of thinking.⁵⁹

2.6.1.3.3. The Psychometric Approach

The theory deals with intelligence, which is defined as “the ability to profit from experience, which implies the ability to behave adaptively, and to function successfully in a particular environment”⁶⁰. Louw and Louw (2014:330) make the argument that in a multicultural country such as South Africa, that the development of intelligence tests which are fair to all cultures has proven to be difficult and as a result many psychologists contend that intelligence tests do not necessarily measure people's everyday abilities.

⁵⁸ Louw & Louw (2014:329).

⁵⁹ Louw & Louw (2014:329).

⁶⁰ Louw & Louw (2014:330).

However, all is not lost and one need only consider the work of Gardner (1983; 1999; 2006), who recognises the following 8 multiple intelligences being: logical-mathematical, linguistic, spatial, bodily-kinaesthetic, musical, interpersonal, intrapersonal, and naturalist intelligences. This is in part because Gardner is not alone in viewing the existing measures of intelligence as overly narrow and related more too academic than real-life experiences.

It is this interplay that needs to be considered when allowing for cognitive development that utilises the concrete and the abstract.

2.6.2. Adolescence and Language Development

One needs to carefully consider the development of language for it is generally this medium by which people are afforded the opportunity to express themselves. “The effect of schooling is also noticeable in children's language development. Even for basic concepts such as ‘cat’, schooling can bring about fundamental changes in conceptual structure.”⁶¹

MacWhinney (2010) submits that:

“educators and parents often complain about the decrease in young people's ability to recall, integrate and internalise significant facts, specifically because they have easy access to knowledge at the press of a button. In order to maintain continuity, young people still need to be able to apply the electronically acquired knowledge”.

It should be noted that this knowledge at the press of a button is a gross misnomer as a vast majority of South Africans live in conditions which preclude them from being able to access that information at the mere press of a button or even within the formal schooling settings.

It should never be forgotten that South Africa has eleven official languages and that most of these have not been developed to the same extent as others. This has become a bone of contention that has seen a multitude of student discontent and political

⁶¹ Louw & Louw (2014:333).

pandering, all in the noble pursuit of having children develop in the language of their choice.

2.6.3. The Impact of Cognitive Development on Adolescence

Now that the foundations have been laid it is best to see how they are built upon. What will be discussed next are the effects of practical cognition on certain areas of adolescent development, which is of import as cognitive development in adolescence functions as an organisational core that affects all thought⁶².

The most noticeable implications are found in formal structures, and for present purposes the classroom, where cognitive developments prepare adolescents for new challenges.⁶³ As mathematics, science and literature require increasingly abstract and logical thought, the adolescent acquires and perfects inductive reasoning, whereby a person reasons from the particular to the general, and deductive reasoning, whereby a person reasons from the general to the particular.⁶⁴ The adolescent can “gather facts to support or oppose principles, generate a range of possible alternatives for any situation, think in abstraction, and test their thoughts against inner logic”, all of which sets them apart from younger children and allows new forms of learning.⁶⁵

“[A]dolescents’ advances in cognitive developments can also affect their study skills” and that owing to the improvement of their metacognitive skills “adolescents are better able than younger children are to identify the gaps in their knowledge and to adjust the way in which they study to compensate for these gaps”.⁶⁶ Accordingly, adolescents do possess the capacity and that if nurtured and given an opportunity to participate they can self-correct and self-regulate and thereby improve.

⁶² Louw & Louw (2014:332).

⁶³ MacWhinney (2010) notes that schooling is most noticeable in a child’s language development.

⁶⁴ Louw & Louw (2014:332).

⁶⁵ Louw & Louw (2014:332-333). Ginsburg and Opper (1988:12) notes that the adolescent begins with the hypothetical, imagining all results, whereafter experiments are devised to test hypothesis concluding in certainty, if done correctly.

⁶⁶ Louw & Louw (2014:333).

“[T]he ability to use abstract and hypothetico-deductive reasoning results in adolescents’ ability to gather facts and ideas to build the case” which could result in argumentativeness, being the one complaint that all parents have against children.⁶⁷ However, “adolescents’ capacity for effective argumentation, idealism and criticism opens the door to intellectually stimulating pastimes such as debate and endless discussion sessions with friends over moral, ethical and political concerns. By proposing, justifying, criticising and defending a variety of solutions adolescents often move to a higher level of understanding”⁶⁸.

With the above in mind it is perhaps advisable for anyone engaging with the child, and if the child is in a position to do so, to engage in this argumentativeness and to test whether the child is at this stage where a child can make its own decisions based on hypothetico-deductive reasoning and to perhaps determine from there what the child's level of cognitive development is.

It was discussed at the onset of this thesis that it will consider cognitive as well as social development and in this instance, social cognition refers to the way in which one thinks about other people, social relationships and social institutions.⁶⁹ Housed within social cognition is the perspective-taking approach which refers to the “ability to consider a situation from the point of view other than one's own”⁷⁰. At about age of 10 to 12, a child becomes capable of mutual perspective-taking, which allows that child to “understand that their perspective-taking interactions with others are mutual - just as you understand that another person has a view that is different from your own, you also realise that other persons understand that you have a view that is different from their own”⁷¹.

During the late stages of adolescence social and conventional system perspective-taking develops, which means that adolescents realise that their social perspectives and those of others are influenced by their interactions with one another as well as by their roles within the wider society.⁷²

⁶⁷ Louw & Louw (2014:333).

⁶⁸ Louw & Louw (2014:334).

⁶⁹ Louw & Louw (2014:334).

⁷⁰ Louw & Louw (2014:334) which notes the extensive work done by Robert Selman (1976; 1980).

⁷¹ Louw & Louw (2014:334).

⁷² Louw & Louw (2014:334).

It is suggested that this is particularly true in South Africa where cultural roles are assigned to people and people are made aware of these throughout their lives. These cultural roles greatly impact not only the mutual perspective-taking but the social and convention system perspective-taking as well, which would ultimately then influence a lot of children's development. Louw and Louw (2014:334) submit that another aspect of social cognition involves making judgements about what others are like and why they behave as they do.

With respect to self-consciousness and self-focusing Louw and Louw (2014:335) infer that an adolescent's "ability to reflect on their own thoughts combined with the physical and psychological changes that they are undergoing mean that they start to think more about themselves. Piaget believed that the new form of egocentrism accompanies this stage – the inability to distinguish the abstract perspectives of self and other".

The ideas were expanded by Elkind (1967; 1985) in that "adolescent egocentrism includes two distorted images of the relation between self and others - the imaginary audience and the personal fable". "People of all ages experience what is known as an optimistic bias, which is a tendency to assume that accidents, diseases and other misfortunes are more likely to happen to others than to themselves"⁷³ and accordingly one should not be quick to dismiss this as an indication that the child is sufficiently mature, but rather that the child has developed accordingly.

According to Louw and Louw (2014:336) adolescents who think more analytically, are better equipped to deal with cognitive tasks more effectively than they did when they were younger. Here cognitive self-regulation, which entails "planning what to do first and what to do next, monitoring progress towards a goal and redirecting actions that prove unsuccessful"⁷⁴, forms an important part of analytical thought.

The question that then arises is can an adolescent make decisions competently? In this respect the Louw and Louw (2014:336-337) submit that the behavioural decision

⁷³ Arnett (2004).

⁷⁴ Louw & Louw (2014:336).

theory, is a worthy point of departure, showing that the decision-making process includes: firstly, identifying the range of possible choices; secondly, identifying the consequences that would result from each choice; thirdly, evaluating the consequence; fourthly, assessing the likelihood of each consequence; and lastly, integrating this consequence. This can be effected through interactions with the child and providing not only the required information but doing so in a manner that is appropriate to the child and with the requisite patience that will result in a meaningful decision being made.

In light of the above “[c]ompetent decision-making involves not only cognitive components but psychosocial components” and that a “deficiency in either area undermines the decision-making process”⁷⁵, with the result being that “even though adolescents may show the same level of cognitive ability as adults in making a decision...adolescents are much more affected by the psychosocial factors...and will therefore make different decisions”⁷⁶.

2.6.4. Schooling and Adolescence

Schooling plays a large part in the development of a child and that “although the resources differ markedly in the various schools, the quality of teaching plays a defining role in children's satisfaction at school and their motivation to learn and to succeed”⁷⁷. Louw and Louw (2014:338) caution that:

“[a]dolescents and teachers are more satisfied in classes that combine structure with high learner involvement and high teacher support. Learners do best when their teachers spend a high proportion of time on lessons, begin or end lessons on time, provide clear feedback to pupils about what is expected of them and about their performance, and give ample praise when they perform well. By encouraging learners and boosting their self-esteem, teachers equip pupils with confidence in a world that is plagued with uncertainty”.

⁷⁵ Steinberg & Cauffman (1996).

⁷⁶ Louw & Louw (2014:337).

⁷⁷ Bray et al (2010).

However, one should be mindful of the circumstances within South African schools that might go a long way toward explaining the ever increasing disinterest in learning, which is disheartening as adolescent achievement rests not only in the hands of their teachers but that “[a]part from their cognitive abilities, adolescents’ own attitudes, expectations, beliefs and motivation also play a role”⁷⁸.

2.7. Personality Development

Personality development includes concepts such as temperament and personality traits, adaptive functioning, and the psychological perspective. It should be noted that in terms of the former:

“temperament and personality have a strong basis in biology, [and] they are not determined solely by genes. Rather, the reciprocal influence between genes, other biological processes, the environment...and behaviour in the course of temperament and personality development must also be considered. Life experiences, especially interpersonal experiences, are particularly important shapers of temperament and personality.”⁷⁹

Baltes & Baltes (1990) describe the following factors which ultimately contribute towards proper adaptive functioning: selection, referring to the identifying of one's goals, committing to them and limiting oneself to a smaller number of tasks from all of the available options; optimism, referring to the directing of one's effort, energy, time and other resources towards one's goals; and compensation, referring to efforts directed at overcoming limitations or a scarcity of resources.⁸⁰ Freund & Baltes (2002) advise that “researchers have indicated that people who use this function at a high level report higher well-being and satisfaction with life”.

With respect of the psychoanalytic perspective one needs to consider the work of Freud and Erikson, however, one should also note that the central crisis during adolescence is the development of an identity.⁸¹ Identity, Louw and Louw (2014:342),

⁷⁸ Louw & Louw (2014:338).

⁷⁹ Louw & Louw (2014:341).

⁸⁰ Louw & Louw (2014:341).

⁸¹ Louw & Louw (2014:341-342).

refers to “an individual's awareness of him- or herself as an independent, unique person with a specific place in society”. It is perhaps appropriate to state that even in communitarian societies people are still regarded, to a certain extent, as independent and unique, but to a larger extent as having a specific place within society.

When considering the development of identity, “adolescents should have acquired basic trust, autonomy, initiative and industry to accomplish successfully the tasks required for identity development” by the time they arrive there⁸² and that in order for them to continue to develop their own identity the following tasks need to be mastered: ego synthesis; socio-cultural identity; gender-role identity; career identity; and own value system.⁸³

Erikson (1950) states that “the successful completion of these tasks will promote adolescents’ sense of identity and thus limit confusion” and that:

“the establishment of an identity provides a sense of faithfulness or fidelity. This means that through self-examination, experimentation and formulation of an own value system and philosophy of life, they know who they are and what they want from life. Therefore, they can be faithful to their own values and principles. This establishes self-confidence.”⁸⁴

The authors⁸⁵ point out, however, that Erikson's use of the term crisis or identity crisis implied an active search for an identity during adolescence and that this created incorrect impressions and suggested that all of this happens at a specific point during adolescence. Furthermore, according to Erikson⁸⁶, the identity development crisis occurred early in adolescence and is resolved between the ages of 15 and 18, which is overly optimistic, and lastly, adolescents do not form their identity simultaneously across all areas as has been implied by Erikson.

⁸² Louw & Louw (2014:342).

⁸³ Louw & Louw (2014:342-343).

⁸⁴ Louw & Louw (2014:343).

⁸⁵ Louw & Louw (2014:344).

⁸⁶ Louw & Louw (2014:344).

It is thus suggested that one look at the work of Marcia (1980) and the accompanying theory on the formulation of identity statuses, which notes that the identity status of an adolescent is “determined according to the crises that they have already worked through...and by the degree and kind of commitment to these choices”⁸⁷. The four statuses are: Status 1 identity achievement; Status 2 identity moratorium; Status 3 identity foreclosure; and Status 4 identity diffusion.⁸⁸

Louw and Louw (2014:344) propose that adolescents begin their identity development in status 3 and 4 and then status 2 and finally the identity achievement status 1. Furthermore, adolescents can achieve different statuses in different aspects of their lives.

The following factors contribute toward identity formation:⁸⁹ cognitive development; parenting; peer interactions; school and communities; personality; and socio-cultural and socio-political events. Louw and Louw (2014:246) stress that one of the important aspects is that of forming a group identity, which in a culturally diverse country such as South Africa may be challenging as “South Africans tend to identify themselves first by racial categories, followed by linguistic, religious, occupational and personal categories, but also simultaneously by an overarching South African identity”.

We have thus been exposed to the need to utilise various facets of development to improve upon and shape other facets. The cognitive development embarked upon may affect social as well as identity development and vice versa.

2.7.1. Adolescents’ understanding of self

The need to develop as a being and as a member of a community becomes challenging in the present instance as South Africa is a cauldron of various cultures being individualistic or communication in nature. According to Louw and Louw (2014:350) adolescents “think of themselves differently than younger children do in a variety of ways. The changes in self-understanding that occur during this stage are

⁸⁷ Louw & Louw (2014:344).

⁸⁸ Louw & Louw (2014:344).

⁸⁹ Louw & Louw (2014:346).

closely related to the changes in cognitive functioning. As with their cognitive development, adolescents' conceptions of self also become more abstract and more complex".

"One aspect of the capacity for abstraction in adolescents' self-conceptions is their ability to distinguish between an actual self or possible self" and that this ultimately results in an ideal self and the feared itself.⁹⁰ Louw and Louw (2014:350) submit that "both kinds of possible selves require adolescents to think abstractly" and thus, the "possible selves exist as abstractions, or ideas in the adolescent's mind". Thus, the adolescent can explore themselves as well as their place within society. The latter predominantly framed in correct and favourable interactions.

A further aspect of adolescent self-understanding "reflects their formal operational cognitive ability to perceive multiple aspects of the situation or idea" as they "acquire the ability to describe themselves in contradictory ways" becomes more complex in the beginning and intermediary stages of adolescence.⁹¹

Self-esteem is also a critical part of this development and refers to "the way a person views and evaluates himself or herself", which means that they "begin to include their cognitive, physical and social skills in their overall opinion of themselves".⁹²

Louw and Louw (2014:351) reflect on the effect that puberty has on self-esteem in that "[d]uring early adolescence, when the growth spurt, pubertal changes and cognitive and social changes occur and adolescents most likely have to adjust to a high school environment, they are inclined to experience a temporary decline in their self-esteem" and that "adolescents with mostly favourable self-esteem profiles tend to be well-adjusted, sociable and conscientious. In contrast, low self-esteem in all areas is linked to adjustment difficulties".⁹³ It goes without saying that a better understanding of oneself and how that self is positioned in society will greatly assist the child, and any adult for that matter, in making more informed decisions.

⁹⁰ Louw & Louw (2014:350).

⁹¹ Louw & Louw (2014:350-351).

⁹² Louw & Louw (2014:351).

⁹³ Louw & Louw (2014:352).

2.7.1.1. Culture and Self-Esteem

This section concludes with a consideration of culture and the self, as this has a great impact on whether one is independently minded or interdependently minded and how one develops socially.

It is important to remember that there are cultures that promote “an independent, individualistic self also promote and encourage reflection about the self” and that this is seen as a “good thing to think about yourself, to consider who you are as an independent person and to think highly of yourself”.⁹⁴ This is in contrast to collectivist cultures, which are “generally characterised by narrow socialisation, an interdependent conception of the self prevails. In these cultures, the interests of the group - the family, the kingship group, the ethnic group, the nation, and the religious institution - are supposed to come first, before the needs of the individual”.⁹⁵

Louw and Louw (2014:354) put forward that:

“children and adolescents in these cultures are socialised to consider the interests and needs of others as at least as important as the needs and interests of themselves. By adolescence, this means that the self is thought of not so much as a separate, independent being, but as defined to a large extent by the relationship with others. From the perspective of interdependence, which is valued by collectivistic cultures, the self cannot be understood apart from the social roles and obligations”.

It is thus noteworthy to highlight the need to consider the cultural context of the child and perhaps more importantly the parents or caregivers. The authors consider that “[b]ecause these differences are difficult to explain solely within the concepts of individualism and collectivism, a tentative explanation incorporating the concept of optimism has been suggested. Optimism refers to the attitude that things happen for the best and that people's wishes or aims will ultimately be fulfilled”.⁹⁶

⁹⁴ Louw & Louw (2014:353).

⁹⁵ Louw & Louw (2014:353-354).

⁹⁶ Louw & Louw (2014:354).

2.7.1.2. Social development

Now that the nuances of the various interactions within development have been elaborated upon the section will conclude with social development. It is concluded that at present “a more balanced view is maintained by focusing on the attachment bonds between parent and adolescent and the support system that parents provide as adolescents enter a wider and more complex social environment”⁹⁷, predominantly as a result of the fact that all other development occurs within the social context.

It is highlighted that within familial social interactions “[c]onflict tends to occur more between adolescents and their mothers... probably because mothers are more involved in the day-to-day activities of the adolescent”.⁹⁸ However, this may no longer be an accurate assessment in no small part due to role being filled by either a member of the extended family or a sibling. Louw and Louw (2014:362) concludes that the “conflict does not necessarily undermine the bonds of love between parents and adolescents; a certain degree of conflict is unavoidable and even necessary for personality growth”.

The authors put forward that part of this development will include autonomy and attachment and that cognitive autonomy “involves making decisions and assuming responsibility for these choices” while behavioural autonomy “implies making choices regarding friendships, leisure time and finances”.⁹⁹ They further mention that emotional autonomy “concerns being self-reliant and independent of their parents and being able to exert self-control”.¹⁰⁰ Louw and Louw (2014:364) conclude by highlighting that moral or value autonomy “refers to forming an own value system that may serve as a guideline for their own behaviour”.

All of these autonomy types regulate social interactions and it is presumed that they will be modified as and when needed:

⁹⁷ Louw & Louw (2014:361).

⁹⁸ Louw & Louw (2014:362).

⁹⁹ Louw & Louw (2014:363-364).

¹⁰⁰ Louw & Louw (2014:364).

“adolescence is a crucial period for the development of abstract thinking skills, which leads to full integration of moral principles and values. Moreover, as their lives become more complex, they increasingly develop qualities and capacities related to moral functioning. Adolescents develop their moral self-concept based on their daily experience, where they have to make decisions and regulate their behaviour when coping with new challenges and social influences. Moral experiences and expertise gained in adolescence form the foundation of mature moral character, identity and action”.¹⁰¹

Moral development forms an integral part of how one regulates social interactions. The psychoanalytic theory offers that “[b]y means of the unconscious process of identification, the cultural values and norms of the parents are transferred to their children and in so doing, the survival of societies is insured”.¹⁰²

Furthermore, the social learning theory advocates that “people are considered as active agents who pursue their goals in accordance with personal values”.¹⁰³ Lastly, the cognitive perspective directs that “the development of moral reasoning and judgement progresses through three levels, each consisting of two stages. These levels are: the pre-conventional level, the conventional level and the post conventional level”.¹⁰⁴ It is offered (2014:382) that Kohlberg's theory of moral development made an “important contribution to knowledge concerning the development of moral reasoning of children, adolescents and young adults. It also stimulated research on moral reasoning in many countries, including South Africa”.

However, everything that does influence development is found here and that what particularly influences moral development is things such as: cognition; personality; parental attitudes and actions; peer interaction; religion; schooling; and the demographical region one finds oneself in.¹⁰⁵

¹⁰¹ Paciello et al (2013).

¹⁰² Louw & Louw (2014:380).

¹⁰³ Bandura (2006).

¹⁰⁴ Kohlberg (1969; 1984; 1987).

¹⁰⁵ Louw & Louw (2014:385).

2.8. Concluding Remarks

It is clear that not only do children possess varying degrees of competency and capacity but that this is greatly affected by not only their cognitive development but their physical and social development as well. The theories and information provided herein above serve to not only remind the reader that children are constantly developing but that they are developing in a structured and natural manner that will see them develop cognitive capacities with which they will make reason of their world and interact with it in a manner that is intended to be beneficial.

Thus, as per the definition of Ganya et al (2016:5) a “child has sufficient maturity to consent to medical treatment insofar as he or she can independently demonstrate (or be facilitated either by aids or a helper as far as it is practically possible in that given setting to possess) the commensurate wherewithal required to assume responsibility for that specific decision”, it is clear that children are, at least for the purposes of the Children’s Act, capable of taking responsibility for their choices and thus are to be considered sufficiently mature in their own decision making process.

CHAPTER THREE

Ethics, a brief summary

“It is a mistake in biomedical ethics to assign priority to any basic principle over other basic principles... The best strategy is to appreciate both the contributions and the limits of various principles, virtues, and rights...”¹⁰⁶

3.1. Introduction

This chapter seeks to assist the health care provider in utilising the most appropriate combination of ethical theories when navigating the legal landscape with respect to minors.

Ganya et al (2016:3-4) state that children “have moral status (or moral worth) plainly by virtue of being humans or persons” which as the thesis has suggested in Chapter 2 as well as in Chapter 4 is a view that has not, and to some extent is not, shared by Western and non-Western societies:

“It is rather best assuming a value theory that does not in any manner legitimise preferences to the acquisition of certain capacities in the development of persons in order for us to arrive upon the conclusion of equal rights and moral status of all persons plainly by virtue of their humanity.”¹⁰⁷

Rakotsoane and van Niekerk (2017: 253) by way of example highlight the Microbicide Study in which Moodley (2007) noted that in the sub-Saharan African context respect for autonomy is often limited by the “influence of the partner, family or society of the individual”. This serves to highlight that a value theory as proposed by Ganya et al is not the norm and that it is a worthy end to strive toward, and one that should be sought.

The theories although they are vast, are most commonly applied in respect of the core principles as first articulated in the Belmont Report and thereafter developed by Beauchamp and Childress. This chapter will begin with a history of the need for biomedical ethics, at the end of which it will provide a summary of the most commonly

¹⁰⁶ Beauchamp & Childress (2013:ix).

¹⁰⁷ Ganya et al (2016:4).

utilised moral theories. The chapter will consider the field as whole, considering aspects of research as well as clinical ethics, and does so to impress upon the reader the importance of these approaches as well as lay the foundation for their legal implications. The chapter will end with a suggestion on how to utilise the aforementioned in the treatment of minors within the legal landscape, from the view of Ubuntu.

As mentioned previously the desired outcome is to provide an appropriate understanding of the development of the field of bioethics in an effort to support the development of the definition. Ganya et al propose their definition subject to certain constraints such as treatment being confined to non-invasive interventions.¹⁰⁸

3.2. A history of the need for bioethics

After the Second World War, although the world had been rife with medical related atrocities prior to and after e.g. the Tuskegee Study, it became clear that the ethics of health care needed to reform and it was here that Bioethics was born. It was birthed by the Nuremberg Code, and was moulded and refined based upon the medical and scientific community's needs. The Belmont Report was the outcome of this moulding process, eventually taking the form of Principlism.

3.3. The Nuremberg Code

On December 9th, 1946, the Nuremberg Military Tribunal opened criminal proceedings against 23 leading German physicians and administrators for their willing participation in War Crimes and Crimes Against Humanity.¹⁰⁹ The charges were numerous but what stood out was that physicians had conducted medical experiments on thousands of concentration camp prisoners without their consent, which resulted in the death or disability of most of the participants.¹¹⁰

¹⁰⁸ Ganya et al (2016:2).

¹⁰⁹ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016

¹¹⁰ Claremont Graduate University – History of Ethics - <http://www.cgu.edu/pages/1722.asp> - 28 March 2016

The Nuremberg Trials¹¹¹ were responsible for the creation of the Nuremberg Code which was introduced in 1947¹¹². The Code states that "[t]he voluntary consent of the human participant is absolutely essential," thereby making it clear that participants must give consent. A consequence of the above is that the benefits of research must outweigh the risks.¹¹³

3.3.1. Ethical Considerations as required by the Nuremberg Code

Firstly, the Code begins by stating¹¹⁴ that the voluntary consent of the human subject is absolutely essential.¹¹⁵ This means that the person involved should have legal capacity to give consent and that they should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion. Furthermore, s/he should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him/her to make an understanding and enlightened decision.

Thus, the duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.¹¹⁶

¹¹¹ This Day in History <http://www.history.com/this-day-in-history/nuremberg-war-crimes-trials-begin> - 25 Jul 2017 notes that the Nuremberg trials began on the 20th of November 1945.

¹¹² Science Museum <http://www.sciencemuseum.org.uk/broughttolife/techniques/nurembergcode> - 25 July 2017 notes that the Code was introduced in August of 2017. However, Shuster (1997) - <http://www.nejm.org/doi/full/10.1056/NEJM199711133372006#t=article> - 25 July 2017 notes that the Code had not immediately been adopted and had taken some twenty years to find adequate standing.

¹¹³ Claremont Graduate University – History of Ethics - <http://www.cgu.edu/pages/1722.asp> - 28 March 2016.

¹¹⁴ "Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10", Vol. 2, pp. 181-182. Washington, D.C.: U.S. Government Printing Office, 1949.

¹¹⁵ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹¹⁶ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

Secondly, the Code states that the experiment should yield fruitful results for the good of society, unprocurable by other methods or means of study, and that it must not be random and unnecessary in nature.¹¹⁷

Thirdly, the Nuremberg Code states that the experiment should be “so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study, that the anticipated results will justify the performance of the experiment”.¹¹⁸

Fourthly, it is stated that the experiment should be conducted so as to avoid all unnecessary suffering and injury.¹¹⁹

Fifthly, it is stated that no experiment should be conducted, where there is reason to believe that death or disability will occur with the exception of those experiments where the persons performing the trial are also the subjects.¹²⁰

Sixthly, the Nuremberg Code states that the degree of risk should never exceed that determined by the humanitarian importance of the problem to be solved.¹²¹

Seventhly, it is stated that the proper preparations should be made and adequate facilities provided to protect the subject against even the most remote possibilities of risk.¹²²

¹¹⁷ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹¹⁸ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹¹⁹ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹²⁰ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹²¹ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹²² US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

Eighthly, it is stated that the experiment should be conducted only by scientifically qualified persons and, furthermore, that the highest degree of skill and care should be required through all stages of the experiment.¹²³

Ninthly, it is stated that during the course of the experiment, the subject should be free to end the experiment, if they have reached the physical or mental state that makes continuing the experiment seem impossible.¹²⁴

Tenthly, the Nuremberg Code concludes by stating that during the course of the experiment, the person in charge must terminate the experiment at any stage, if there is probable cause to believe that a continuation of the experiment is likely to result in injury, disability, or death.¹²⁵

It must be mentioned that although the Nuremberg Code did not carry the force of law, it was the first international document which advocated voluntary participation and informed consent.¹²⁶

3.4. The Belmont Report

On the 18th of April 1979, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research released the Belmont Report.¹²⁷ The Belmont Report states that “[t]he Nuremberg code was drafted as a set of standards for judging physicians and scientists who had conducted biomedical experiments on concentration camp prisoners.”¹²⁸

¹²³ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹²⁴ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹²⁵ US Department of Health and Human Services – The Nuremberg Code - <http://www.hhs.gov/ohrp/archive/nurcode.html> - 28 March 2016.

¹²⁶ Claremont Graduate University – History of Ethics - <http://www.cgu.edu/pages/1722.asp> - 28 March 2016.

¹²⁷ For further information please consult the US Department of Health and Human Services website <http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html>.

¹²⁸ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects.

It was at this historic moment that the three principles, that would later be expanded upon to form Principlism, were articulated. What is crucial is that “[t]hese principles cannot always be applied so as to resolve beyond dispute particular ethical problems. The objective is to provide an analytical framework that will guide the resolution of ethical problems arising from research involving human subjects.”¹²⁹ It is this focus on providing a framework by which the ethical correctness of acts or omissions can be measured that has been continued in this thesis, having being influenced by the work of Ganya et al.

3.4.1. Ethical Requirements as laid down in the Belmont Report

In Part A, Boundaries between Practice & Research, one is introduced to the rigidity and certainty of defined concepts as they appear in the definitions section. One’s attention is clearly drawn to the meaning of “practice” in referring to “interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success.”¹³⁰

The section contains that “[r]esearch’ designates an activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge...”¹³¹

Of legal importance here would be the reliance of “reasonable expectation of success” and what this means in the application of treatment or nontreatment, as this would greatly impact upon the nature of the arguments advanced in relation to autonomy.

In Part B, Basic Ethical Principles, the principles that will form the basis of Bioethics are articulated in that the “[t]hree basic principles, among those generally accepted in our cultural tradition, are particularly relevant to the ethics of research involving human subjects: the principles of respect of persons, beneficence and justice.”¹³² It was the

¹²⁹ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects.

¹³⁰ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects.

¹³¹ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects.

¹³² Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects.

principles of Respect for Persons¹³³, Beneficence¹³⁴ and Justice¹³⁵ that lay the foundations for Principlism as developed by Beauchamp & Childress.

In Part C, Application¹³⁶ is dealt with, which is a crucial aspect in line with the outcomes of this thesis – an ethically and legally acceptable framework for the treatment of minors.

Item 1 of Part C is of great relevance to the task at hand as it deals with the discussions regarding Informed Consent¹³⁷ in that “[r]espect for persons requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them.” The concern in this statement regards the degree to which subjects are capable to consent.

Furthermore, an important component of informed consent is the notion of information in terms of not only its conveyance and understanding but its implementation as well. In regard to the nature of the information “a simple listing of items does not answer the

¹³³ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part B: Basic Ethical Principles notes in Item 1 - Respect for Persons that: “first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection.” It is further noted that “an autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation.” It is strongly emphasised that that “not every human being is capable of self-determination”, an argument that makes the recognition of incompetence all the more necessary as “[t]he extent of protection afforded should depend upon the risk of harm and the likelihood of benefit. The judgment that any individual lacks autonomy should be periodically reevaluated and will vary in different situations.”

¹³⁴ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part B: Basic Ethical Principles notes in Item 2 – Beneficence that the content of beneficence is to do no harm and to maximise possible benefits while minimising possible harm. It should be noted that in avoiding harm requires being aware of what is harmful and “in the process of obtaining this information, persons may be exposed to risk of harm...The problem posed by these imperatives is to decide when it is justifiable to seek certain benefits despite the risks involved, and when the benefits should be foregone because of the risks.”

¹³⁵ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part B: Basic Ethical Principles notes in Item 3 – Justice notes that question of justice is one in the sense of “fairness in distribution” or “what is deserved.” It is further stated that one needs to consider the various formulations of justice in order to address the inequalities present in the system. These formulations are that “(1) to each person an equal share, (2) to each person according to individual need, (3) to each person according to individual effort, (4) to each person according to societal contribution, and (5) to each person according to merit.” Given the grave nature of the atrocities committed “it can be seen how conceptions of justice are relevant to research involving human subjects.”

¹³⁶ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects.

¹³⁷ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

question of what the standard should be for judging how much and what sort of information should be provided.”¹³⁸

Part C suggests that in respect to the utilisation of information, what should be utilised is the standard of the reasonable volunteer in that:

“the extent and nature of information should be such that persons, knowing that the procedure is neither necessary for their care nor perhaps fully understood, can decide whether they wish to participate in the furthering of knowledge. Even when some direct benefit to them is anticipated, the subjects should understand clearly the range of risk and the voluntary nature of participation.”¹³⁹

However, in the event of a failure to inform the user one is allowing for an incomplete disclosure and that with regard to this the text permits that:

“[i]n all cases of research involving incomplete disclosure, such research is justified only if it is clear that (1) incomplete disclosure is truly necessary to accomplish the goals of the research, (2) there are no undisclosed risks to subjects that are more than minimal, and (3) there is an adequate plan for debriefing subjects, when appropriate, and for dissemination of research results to them.”¹⁴⁰

As one is given a greater insight in the nature of the information that is being provided one must be mindful of the participant’s ability to utilise that information. To this end Part C refers to the importance of comprehension or more appropriately the participant’s understanding in that “the manner and context in which information is conveyed is as important as the information itself.”¹⁴¹ This reasoning is discerned in interactions with healthcare users as well. It should be noted that in light of the previous chapter it becomes clear that information and the manner in which it is conveyed is

¹³⁸ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹³⁹ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹⁴⁰ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹⁴¹ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

equally important in the processing of such information at various stages of development.

In continuance of this concept of participation through the incorporation of information in the decision-making process, the Belmont Report states that “[e]ven for these persons, however, respect requires giving them the opportunity to choose to the extent they are able, whether or not to participate in research.”¹⁴² This concept of participation is crucial and it is here that one finds similar concepts in the laws and ethics governing interactions with children.

It thus becomes clear that where no ability or an incomplete ability is present that the one would require that a decision maker be appointed in the user’s stead. What is always to be emphasised is that not only competent but understanding surrogate decision makers are to be appointed in these matters:

“The third parties chosen should be those who are most likely to understand the incompetent subject's situation and to act in that person's best interest. The person authorized to act on behalf of the subject should be given an opportunity to observe the research as it proceeds in order to be able to withdraw the subject from the research, if such action appears in the subject's best interest.”¹⁴³

The concept of voluntariness is in certain instances almost as engaging a consideration as that of consent. Part C lays out the concerns regarding voluntariness¹⁴⁴ in respect to factors influencing voluntariness:

“coercion occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance.”¹⁴⁵

¹⁴² Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹⁴³ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹⁴⁴ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹⁴⁵ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

Item 2 of Part C is similarly important to reasoning as it addresses issues surrounding the Assessment of Risks and Benefits and notes that “the assessment presents both an opportunity and a responsibility to gather systematic and comprehensive information about proposed research.”¹⁴⁶

3.5. The effects of Nuremberg and Belmont on Ethics

The aforementioned instruments not only showed that there was a great need to reformulate the manner in which practitioners approached ethical interactions with users but that there was a very real need to protect future generations from experiencing the same injustices.

The Belmont Report gave rise to the three principles that would eventually be formulated into Principlism. What follows herein below is a summary of the various moral theories that are commonly utilised in the interpretation of the principles and a summary of the principles.

3.6. The relationship between these principles

The core components of Bioethics have been developed to include:

- Respect for individual autonomy;
- Non-Maleficence;
- Beneficence; and
- Justice.¹⁴⁷

The principles are not hierarchical in that one does not “trump” another, however, in the case of a conflict between principles the “weighing and balancing of potential risks and benefits becomes an essential component of the reasoning process in applying

¹⁴⁶ Belmont Report - Ethical Principles & Guidelines for research involving Human Subjects in Part C: Applications.

¹⁴⁷ University of Washington School of Medicine: Ethics in Medicine (2015) confirms the principles as laid out in Beauchamp & Childress (2013) and the Belmont Report (1979).

the principles”.¹⁴⁸ This is the method adopted by our Courts in their interpretation and enforcement of rights as noted in sections 36 and 38 of the Constitution.¹⁴⁹ It would thus be appropriate to determine their applicability in any given situation.¹⁵⁰

In evaluating the principles, it is best to commence with Autonomy as it seems to be most relevant to the aims of the thesis and is the one that receives the most attention and most critique. Beauchamp & Childress (2013:ix) tender that many, in their critique of Principlism, have suggested that autonomy is the overriding principle in the theory, in no small part due to what they “perceive as an American individualist orientation”. Gillon (2015:2-3) in defence of the authors states that the concerns raised by critics tend to reflect an inability to deal with conflict between the various principles.

In an effort to correct the perception Beauchamp & Childress (2013:ix) have made the argument that Respect for Autonomy is not distinctly American nor is it individualistic or overriding. The importance of cultural values, a topic that is dealt with in great detail by many authors is of value at this junction. Cultural relativism needs to be distinguished from the notion of contextualism, as the authors posit it.¹⁵¹ This is crucial in our context as culture plays an important role in South Africa. Cultural relativism has made it possible for one to appreciate the norms and standards by which a particular society functions without considering it inferior. Contextualism, as applied by the authors, relates to a context in which the norms are applied. This is of great import when one considers the norms relating to decision-making and minors in South Africa.

When considering the components of autonomy, it is worth noting, as Beauchamp & Childress (2013:102) state, that “[v]irtually all theories of autonomy view two conditions as essential for autonomy: liberty (independence from controlling influences) and agency (capacity for intentional action).” Thus, in the determination of decision-making it is, as discussed herein above, best to consider the user’s freedom in making the

¹⁴⁸ University of Washington School of Medicine: Ethics in Medicine (2015).

¹⁴⁹ Republic of South Africa. 1996. Constitution of the Republic of South Africa Act 108 of 1996. Available: <http://www.constitutionalcourt.org.za/site/theconstitution/thetext.htm>

¹⁵⁰ University of Washington School of Medicine: Ethics in Medicine (2015) “Since principles are empty of context the application of the principle comes into focus through understanding the unique features and facts that provide context for the case.”

¹⁵¹ Cultural relativism enables one to be acquainted with the intricacies of various cultures and appreciate their uniqueness. However, as discussed in Rachels & Rachels (2012:26-28) it can be in error especially when used to justify an act that cannot be validated in any other context.

choice as well as their understanding of that choice. In our context this freedom arguably seems to be tied to cultural norms and societal legacies, such as education or the lack thereof, and the understanding to both the user and their decision-maker in the appropriate circumstance.

Beauchamp & Childress (2013:105) state that “no fundamental inconsistency exists between autonomy and authority if individuals exercise their autonomy in choosing to accept an institution, tradition, or community that they view as a legitimate source of direction.” Beauchamp & Childress (2013:109), however, are aware that persons are culturally indoctrinated since birth and that their autonomous choices within society could fundamentally be akin to habit and procedure,¹⁵² which could be truer nowhere than in a society that has been forcefully divided along grounds of race and culture, in which culture was influenced and created by laws.

Gillon (2015:3) acknowledges that autonomy is important in restraining, as well as constraining, principles used in a paternalistic frame of mind, as it allows for adequate balancing on a case by case basis. Given the authors propensity toward improvement and betterment, their theory could evaluate and incorporate input such as that provided by Behrens (2013:34) which proposes that Autonomy be rethought of as “respect for persons” and that in making it more inclusive that Justice be reconsidered as “harmony” as there is more to harmonious relationships than justice alone entails.

At this juncture it is worth bearing in mind the points put forward by Ganya et al that Western Liberalism often emphasises rationality and individualism whilst African Communitarianism emphasises the sociality of persons whilst not refuting other dimensions of maturity.¹⁵³

A further critique that has cropped up in other areas is that of the potential misuse of Principlism. Gillon (2015:4-5) notes that what is evident here is that there is the potential to confuse the principle’s use and the principle itself. The confusion extends

¹⁵² Beauchamp & Childress (2013:109) “Persons are both interdependent and in danger of oppressive socialisation and oppressive social relationships that impair their autonomy by conditions that unduly form their desires, beliefs, emotions, and attitudes and improperly thwart the development of the capacities and competencies essential for autonomy.”

¹⁵³ Ganya et al (2016:2).

to the use of simplistic and simplicity with Gillon (2015:5) differentiates that the use of simplistic versions implies that a person is not adequately applying himself or herself, while a simple thing to use is not entirely a bad thing. Gillon states that a message should never be confused with a poor messenger and that the tools available to properly understand and implement the principles are available.¹⁵⁴

Thus, it is clear that each of the principles is best understood not only in terms of its uniqueness but also in terms of how it interacts with the other principles. This interplay is more closely considered herein below when dealing with manoeuvring of Bioethics within the parameters of the legal landscape.

3.7. What is meant by “ethics”?

This section seeks to illustrate the ethical foundations utilised by health care providers in their decision-making processes. Accordingly, as described above there are a wide variety of theories and no singular theory is more deserving than another and thus the section seeks to give a summary on the available theories and concludes by providing some guidance in taking them forward in the context of the South African legal landscape. As a result of this overview, the theories will be more closely applied to minors and “sufficient maturity” in Chapter 5.

Ethics, per definition, is derived from the Greek word “ethos” meaning “custom” or “habit”. In considering the difference between ethics and morals one is drawn to the notion that the former deals with the theory of right action whilst the latter deals with their practice.¹⁵⁵ This is clarified in Socrates’ assertion that “people will naturally do what is good provided that they know what is right and that evil or bad actions are purely the result of their ignorance”.¹⁵⁶ One may infer from this that the underlying rationale for a person’s behaviour is their understanding of the law, an inference that has greatly assisted rights based ethics.

¹⁵⁴ These tools include numerous websites, books, and the MPhil in applied ethics offered by the University of Stellenbosch.

¹⁵⁵ The Basics of Philosophy (Ethics), 2015

¹⁵⁶ The Basics of Philosophy (Ethics), 2015

In the assessment of moral theories, it is crucial that one adhere to accredited criteria. Beauchamp & Childress (2013:352) specify that an ethical theory's task is to "reflect critically on influential moral norms and practices" and to this effect state that "[i]n general, theories will seem most adequate if they are judged as best suited to some limited range of morality, rather than to all of it".

For one to determine how things ought to be, and by inference what is right, one would need to consider the content of Normative Ethics, which attempts to develop a set of rules for the governing of human conduct, or a set of norms to direct action.¹⁵⁷ The most easily accessible analogy would be that of any legal regime and it is here that one can start down the route of Human Rights as they are most accessible in law.

3.8. The prevailing theories on ethics

3.8.1. Utilitarianism

Utilitarianism is a division of Consequentialism¹⁵⁸ which argues that the morality of an action is dependent on the action's outcome or result.¹⁵⁹ A morally right action is thus an action that produces a good outcome or consequence.¹⁶⁰ According to Beauchamp & Childress (2013:354) it "concentrates on the value of well-being, which has been analysed in terms of pleasure, happiness, welfare, preference satisfaction, and the like".

¹⁵⁷ The Basics of Philosophy (Ethics), 2015.

¹⁵⁸ Beauchamp & Childress (2013:355) notes that "[i]t is consequentialist because the moral rightness and obligatoriness of actions are established by their results... [i]t is impersonal and aggregative because a judgment about right or obligatory action depends on an impartial appraisal of the effects of different possible actions on the welfare of all affected parties, which entails summing those positive and negative effects over all persons affected".

¹⁵⁹ Beauchamp & Childress (2013:355), state that the principle of utility "asserts that we ought always to produce the maximal balance of positive value over disvalue – or at least possible disvalue, if only undesirable results can be achieved".

¹⁶⁰ (The Basics of Philosophy (Ethics), 2015) and (The Basics of Philosophy (Utilitarianism), 2015) Note that utilitarianism is the idea that the moral worth of an action is solely determined by its contribution to overall utility in maximising happiness or pleasure as summed among all people. To paraphrase Spock, played by the late Leonard Nimoy, "the needs of the many outweigh the needs of the few".

Utilitarianism holds that an action is right if it results in the most happiness for the greatest number of people.¹⁶¹ Beauchamp & Childress (2013:355-6) articulate that there are differing definitions of utility proffered by various utilitarians and that utility changed from the original concepts to a broader range of values other than happiness. What started out as rather hedonistic has developed into a broad discussion as to whose definition is best suited to maximising utility.

3.8.2. Deontology

The second school is Deontology¹⁶² which is an approach to ethics that focuses on the rightness or wrongness of the actions themselves, as opposed to the rightness or wrongness of the consequences of those actions.¹⁶³ It argues that ethical rules bind people to their duty¹⁶⁴ and as such decisions should be made considering the factors of one's duties and other's rights.¹⁶⁵

3.8.3. Virtue Ethics

The third school is Virtue Ethics¹⁶⁶ which focuses on the inherent character of a person rather than on the nature or consequences of specific actions performed. The theory identifies virtues¹⁶⁷ (habits and behaviours that will enable a person to achieve

¹⁶¹ (The Basics of Philosophy (Ethics), 2015) where happiness is, accordingly, defined as the maximisation of pleasure and the minimisation of pain. (The Basics of Philosophy (Utilitarianism), 2015) notes that measuring happiness across different people is impossible, although defenders have argued that rough estimates are sufficient.

¹⁶² Deon in Greek means "obligatory" or "duty".

¹⁶³ (The Basics of Philosophy (Ethics), 2015). Beauchamp & Childress (2013:361) note that it is "a theory of duty holding that some features of actions other than or in addition to consequences make actions right or wrong".

¹⁶⁴ The Basics of Philosophy (Deontology), 2015.

¹⁶⁵ (The Basics of Philosophy (Ethics), 2015). (The Basics of Philosophy (Deontology), 2015) to a deontologist whether a situation is good or bad depends on whether the action that brought it about was right or wrong. What makes a choice right is its conformity with a moral norm: right takes priority over good. However, (University of Washington School of Medicine: Ethics in Medicine, 2015) notes concerns about the principle of double effect given the understanding that all that is important is the action that brought about the result. It states that an action may have both a good and a bad effect. It notes that we look at (i) the nature of the act; (ii) the agent's intention; (iii) the distinction between means and effects; and (iv) the proportionality between the good effect and the bad effect.

¹⁶⁶ Beauchamp & Childress (2013:383) "Virtue theory is the most venerable type of moral theory, with a beautiful tradition descending from the ancient world to modern times, and it has also been enhanced by some impressive recent theories."

¹⁶⁷ Beauchamp & Childress (2013:378) "[a] virtue is a deeply entrenched morally good and commended trait of character that makes a person morally reliable..."

“*eudaimonia*” or a good life)¹⁶⁸. Furthermore, it states the indispensability of practical wisdom¹⁶⁹ in resolving any conflicts that may arise between virtues and a life lived in pursuit thereof.¹⁷⁰

In contrast to the moral worthiness of an action, as proposed by deontology, virtue ethics allows for a virtuous person to experience “appropriate feelings, such as sympathy and regret”. This allows the person to act in accordance with what is morally right and worthy.¹⁷¹ It is crucial that the following distinction is made in that, although “such a trait disposes a person to perform right actions” that the theory proposes that one’s starting point needs to be the character traits that enable and dispose a person to right actions.¹⁷²

The theory has, however, itself been subject to critique the most articulated being that of its comprehensiveness as a theory. The argument is that “[i]n speaking of generally admirable character traits as moral virtues, virtue theory cannot speak merely of good, commendable, and useful mental traits. The scope of virtues must be limited to character traits that enable and dispose persons to morally worthy pursuits”.¹⁷³

A further critique, and one that it is somewhat counterintuitive, is that the theory cannot be utilised in any context other than one in which “trust, intimacy, and dependence are present”.¹⁷⁴ The argument is that when strangers meet the theory is insufficient as “...trust, intimacy, familiarity, and the like have not been established... [as] character often plays a less significant role than principles, rules, and institutional policies”.¹⁷⁵

¹⁶⁸ (The Basics of Philosophy (Ethics), 2015) Eudaimonism, as advocated by Aristotle, defines right action as that which leads to “well-being” and which can be achieved by a lifetime of practicing virtues in one’s everyday activities subject to the exercise of practical wisdom.

¹⁶⁹ An idea that has been modified and developed by persons such as Professor AA van Niekerk in his work on an Ethics of Responsibility (Phronesis and an ethics of responsibility, 2013). One is left wondering, however, if this is concept could not be interpreted as common sense for the greater good.

¹⁷⁰ The Basics of Philosophy (Ethics), 2015.

¹⁷¹ Beauchamp & Childress (2013:377).

¹⁷² Beauchamp & Childress (2013:378).

¹⁷³ Beauchamp & Childress (2013:382).

¹⁷⁴ Beauchamp & Childress (2013:383) “Virtues come to the fore in contexts in which trust, intimacy, and dependence are present. Virtue theory is well-suited to help us navigate circumstances of caregiving and the delivery of information in health care.”

¹⁷⁵ Beauchamp & Childress (2013:382).

The argument appears flawed as one would reasonably expect a stranger to have the virtues necessary for their actions to be considered morally worthy. This logic can be extrapolated from the professionalism within the healthcare sector. (A health system that violates patients' rights to access health care, 2012:3) argues that professionalism "...demands a social pact in which society and its institutions expect to be guaranteed certain standards of practice in exchange for professional status, power and prestige".

3.8.4. Rights Theory¹⁷⁶

The theory has become the most important theory regarding the expression of the moral point of view by, *inter alia*, legal practitioners. It is easy to agree with the authors, Beauchamp & Childress (2013:360), in that many participants "presuppose that arguments cannot be persuasive unless stated in the language of rights".¹⁷⁷ Given our constitutional jurisprudence this step was a logical inevitability.

The North Gauteng High Court handed down judgment in a matter concerning end of life decisions.¹⁷⁸ One of the arguments put forward by the Respondents and *amicus curiae* was that rights in terms of the Constitution (Republic of South Africa, 1996)¹⁷⁹ are not absolute and that they need to be interpreted within the ambit of the constitutional framework, an argument similar to that of Beauchamp & Childress (2013:367) in that "[a]ccordingly, all rights, like principles and rules of obligation, are *prima facie*...valid claims that sometime, however rarely, must yield to other claims."

Further argument by the Respondents noted that the Constitution (Republic of South Africa, 1996) "...places an obligation on the state to take reasonable legislative and other measures within the resources available to achieve the progressive realisation of [rights]".¹⁸⁰ In their arguments the parties stressed that the Court needs to "...focus

¹⁷⁶ Beauchamp & Childress (2013:362) "If agents do what is morally right simply because they are scared, because they derive pleasure from doing that kind of act, or because they seek recognition, they lack the requisite goodwill that derives from acting for the sake of the obligation."

¹⁷⁷ Beauchamp & Childress (2013:371) state that "[t]he language of rights is thus transferable into the language of obligations: A right entails an obligation, and an obligation entails a right".

¹⁷⁸ *Stransham-Ford v The Minister of Justice*.

¹⁷⁹ Beauchamp & Childress (2013:375) "Although human rights are often presumed in public discourse to be legal rights, they are best interpreted as universally valid moral rights."

¹⁸⁰ A health system that violates patients' rights to access health care, 2012:2.

on the rights of all the parties, in an effort to determine their meaning and scope as well as their weight and strength”.¹⁸¹ Further arguments dealt with the rights of the incompetent and unidentified members of the populations.¹⁸² A concern that has been developed in accordance with the Bill of Rights and common law.

As with all other theories, Rights Theory is not immune to critique. Beauchamp & Childress (2013:374) note that the theory is “...best understood as a statement of minimal and enforceable rules protective of individual interests that communities and other individuals must observe”. But this is what we recognise law to mean in South Africa and thus it is perfectly suited as a guiding influence for the purposes of this thesis. This interplay requires that the theory “needs to be buttressed by theories of obligation and virtue”.¹⁸³

3.8.5. Ethics of Responsibility

Van Niekerk states that the theory of an Ethics of Responsibility will develop “an approach to moral reasoning...more suitable, and which enables one to incorporate some valuable aspects of [utilitarianism and deontology] without succumbing to their deficiencies”.¹⁸⁴

The core of this theory is that one can provide reasons for their decisions and that one accepts responsibility for these decisions.¹⁸⁵ Van Niekerk suggests that we “have to accept responsibility for whatever we decide” but that certainty is not required of us, as “[w]hat can be demanded...is the full catalogue of our reasons and the arguments supporting them”.¹⁸⁶ It is worth highlighting that the reasons must have been thought through and thus potentially fallible. Thus, when engaging in an ER, we have no assurance of correct moral behaviour, but we do have an assurance of responsible moral behaviour.”¹⁸⁷ This focus on a lack of certainty is easily transferred to the law of

¹⁸¹ Beauchamp & Childress (2013:367).

¹⁸² Beauchamp & Childress (2013:370).

¹⁸³ Beauchamp & Childress (2013:374).

¹⁸⁴ Phronesis and an ethics of responsibility, 2013:28.

¹⁸⁵ (Phronesis and an ethics of responsibility, 2013:28) “...we argue that individuals are accountable to the unconditional claim that others make on them, to (i) be available to others and (ii) to have their interest at heart, irrespective of whether others act reciprocally...”

¹⁸⁶ Phronesis and an ethics of responsibility, 2013:29.

¹⁸⁷ Phronesis and an ethics of responsibility, 2013:29.

delict. The focus on responsibility as opposed to reasonable differs from our law which generally sets the test at reasonableness.

The determining factor in this ability to conceive, develop and implement reasons is what Van Niekerk refers to as “*Phronesis*”, which is defined as “practical knowledge of how to live the good life... [and is] knowledge wherein I try to act in accordance with the precepts or action guides that I acknowledge, and which are prudently applied to the situation in which I find myself, and where I must act in such a way that I can live with the consequences”.¹⁸⁸

Van Niekerk stresses that simply knowing the rules is insufficient and that “they must be responsibly applied in many practical situations...[deliberation] implies the careful weighing up of the claim of the norm against the requirement of the situation”.¹⁸⁹ It is suggested that this should be the standard for all interactions and should dictate how professionals approach their work and the decisions made therein. One might almost refer to this practical knowledge as adherence to the law.

3.8.6. Ubuntu and African Philosophy

Gade (2011) points out that “ubuntu” has been recorded in writing as far back as 1846 but that it has changed from describing a quality to being considered a world view. The author (2011:308) records that prior to 1980 “the term ‘quality’ appears in descriptions of ubuntu, and in many texts ubuntu is evidently considered to be a very positive quality”. However, there seems to be some confusion as to the content of the quality and to whom or what it attaches to¹⁹⁰, with Gade (2012:486-487) stressing that there is no consensus as to the content of ubuntu as it is “a dynamic term that has taken on new meanings at different points in history, probably under the influence of changing social and political circumstances”¹⁹¹.

¹⁸⁸ Phronesis and an ethics of responsibility, 2013:30.

¹⁸⁹ Phronesis and an ethics of responsibility, 2013:30.

¹⁹⁰ Gade (2011: 308) further notes that some authors even narrowed the whom to include only persons of African descent. It would seem that ubuntu found prominence in some circles as a political ideology with Gade (2011:309) noting that it was used as rallying cry to support ethic rule in Zimbabwe in February of 1980.

¹⁹¹ Eze (2008:387) notes that ubuntu “is at once a philosophy and a culture”.

It is further recorded (2011:311-312) that ubuntu formed an integral part of South Africa's Interim Constitution and that this importance has been echoed by the Constitutional Court in numerous judgments.¹⁹² Gade (2012:487-493) offers that the question of what ubuntu is, is housed in two schools of thought, with the first school defining it as moral quality of a person while the second school defines it as a phenomenon. The author (2012:492) concludes that although there is not always an explanation as to the nature of the philosophy that is defined as ubuntu, there is always an explanation that "ubuntu is understood as a phenomenon according to which persons are interconnected".

Louw and Louw (2014:32) argue that "[h]uman behaviour is viewed from an anthropocentric framework because humans are placed in the middle of the universe, from which position everything else is understood", with great emphasis being placed on spirituality. This view is confirmed by Rakotsoane and van Niekerk (2017:255-6) in that this monistic view of reality that has been adopted "places humans at the centre of the concentrically arranged circles" in which human beings do not see themselves as "masters of the universe" but rather as constituent parts of the whole.

Gade (2012:494) points out that at present there are also two schools of thought as to who constitutes a person for purposes of ubuntu. The first group notes that for the purposes of ubuntu that all Homo sapiens are persons, while the second group notes that only some Homo sapiens are persons¹⁹³. However, for purposes of this thesis as well as the Constitutional notion that ubuntu applies to all persons it is this view that will be adopted and not the views that promote exclusion.

The authors (2014:32) highlight that "the personhood and identity of the traditional African is anchored in his or her collective (communal) existence and relatedness. This relatedness is both horizontal and vertical: Horizontally, the person is related to all others in the community, and vertically to the deceased members of the community as

¹⁹² Gade (2012:485) reaffirms the importance placed on ubuntu in South Africa's Constitutional Democracy.

¹⁹³ Gade (2012:494-501) notes that the second group has 3 subsets consisting of: Only Homo sapiens who meet the criterion of being black; or Only Homo sapiens who have met the criterion of having been incorporated into personhood; or Only Homo sapiens who behave in a morally acceptable manner.

well as to those not yet born”. In essence the theory notes that “[i]ndividuals obtain their strengths and identity from family and community to which they belong, while their growth and development are linked closely to their kinship relationships. These relationships bind and support the individual and is linked to the expression, ‘I am because we are; and because we are, I am’.”¹⁹⁴

Eze (2008:386) puts forward that the “relationship between the individual and the community is dialogical for the identity of the individual and the community is dependent on this constitutive formation...[t]he individual is not prior to the community and neither is the community prior to the individual”. The author (2008:388) goes on to state that “the identity or subjectivity of the individual and the community are mutually constitutive and hence none is supreme”.

As “a person’s humanity is dependent on the appreciation, preservation and affirmation of other person’s humanity...To deny another’s humanity is to depreciate my own humanity”¹⁹⁵. However, Gade (2011:313) concludes that the development of ubuntu from a quality to a philosophy, predominantly in as far as it is linked to the proverb “umuntu ngumuntu ngabantu”¹⁹⁶, only took place in the period between 1993 and 1995 in no small part as a result of the first book in English to deal with the subject matter.

This interconnection, with its particular place in time and purpose being elaborated upon herein above, was alluded to in Chapters 1 and 2. For purposes of this thesis that this interconnection is seen as guiding the decision-making process both from a development point of view as well as a cultural one.¹⁹⁷ Minors, it would seem, cannot escape the normative view cast on them by society.

¹⁹⁴ Louw and Louw, (2014:32-33).

¹⁹⁵ Eze (2008:387).

¹⁹⁶ Gade (2011:313) notes that the proverb translates to a person becomes a person through other persons.

¹⁹⁷ Eze (2008:389) shares this view in that an “individual’s subjectivity emanates from the social-intercourse within specific cultural contexts” and that the “identity of the community and the individual is given essence in terms of such trivially inter-subjective formations”.

It is this interconnectedness that has allowed for Rakotsoane and van Niekerk (2017) to further existing work and highlight the emerging African bioethics principle of “Ha le fete khomo le je motho” or human life invaluableness. The authors (2017: 253) confirm that the principle began its existence as a proverb meant to dissuade the killing of a captive or enemy combatant, and that the proverb is used to invoke informed decision-making processes. The authors (2017:253) conclude that the result of this proverb is the inference that it is morally wrong to kill a human being.¹⁹⁸

The principle has found its way into modern times, as predominately the overriding consideration for the care of a human being. Rakotsoane and van Niekerk (2017:254) argue that the proverb is used to defend and justify the expenditure of resources on human health, as “[o]nce uttered, no further question is asked because of the authoritative nature of proverbs.”

Rakotsoane and van Niekerk (2017:256-7) suggest that life is considered not from a moral viewpoint, noting good and evil, but from an ontological one, noting that a life is a life, in situations where “one has to choose between spending resources in order to save life and sparing resources at the expense of potentially saving a saveable life”.

This principle presents “human life as something invaluable and therefore worth spending one’s resources on, even if it means spending them at the expense of other necessities of life”¹⁹⁹. The principle of human life invaluableness should be seen as the “basis for everything that is done in connection with saving the life of a loved one”.²⁰⁰ The thesis argues that it is easy to extend the principle to include all situations short of life threatening circumstances as the principle can be applied to the improvement of medical conditions and infirmities short of the life threatening variety.

¹⁹⁸ Eze (2008:388) notes that the conclusion of the numerous proverbs and aphorisms is that the “relationship between the individual and the community is contemporaneous, the community in this context does not act as a self-generating end but furnishes those values that will enhance human identity”.

¹⁹⁹ Rakotsoane and van Niekerk (2017:258).

²⁰⁰ Rakotsoane and van Niekerk (2017:258).

3.8.7. Conclusion derived from the prevailing theories on ethics

It becomes clear that the most appropriate course of action in terms of the aforementioned theories is not the blind obedience to a single school but to the adaptation of the theories to the situation at hand and more importantly the reasoning in dealing with that situation.

The literature suggests that the principles do not offer dilemma resolution mechanisms. Theories such as Virtue Ethics, Rights Theory, Ubuntu and an Ethics of Responsibility create the mechanisms required in addressing these deficiencies especially within the South African context. Virtue Ethics, by way of example, is best suited in addressing the relationship between parties. An Ethics of Responsibility would best address the issues concerning moral worthiness of actions as it moves away from the duty and intention to the reasoning. Rights Theory creates the foundation that “individuals hold justified claims that they can exercise. They are not beholden to the moral beneficence of other people”.²⁰¹

The present exercise may be likened to clay in the philosopher’s hands in that we have the opportunity to mould what we have in order to make something better. It has been accepted that there is no all-encompassing theory²⁰² and that one needs to extract the most appropriate elements for the given situation. In improving upon the theories discussed above we should look toward aspects of theories that not only strengthen but compliment as well.²⁰³ The following will evaluate the interplay between the theories discussed above and the moral theories of Virtue Ethics, Rights Theory, Ubuntu and an Ethics of Responsibility. These will serve as the grounds upon which Human rights and Principlism will be interpreted and utilised by our courts in applying the law.

²⁰¹ Beauchamp & Childress (2013:369-70).

²⁰² (University of Washington School of Medicine: Ethics in Medicine, 2015) “Indeed, Beauchamp and Childress do not claim that Principlism provides a general moral theory, but rather, they affirm the usefulness of these principles in reflecting on moral problems and in moving to an ethical resolution.”

²⁰³ Beauchamp & Childress (2013:376) agree with authors that “we contend that it is appropriate to consider virtue ethics as an alternative type of theory even though it does not address exactly the same questions as utilitarian, Kantian, or even rights theories”.

It has been argued that virtues i.e. compassion and humanity, and not principles should underpin medical ethics. Gillon (2015:2-3) notes that this reasoning is premised on the notion that Principlism leaves little or no room for virtues. In this regard one might adopt the approach encapsulated in the Ethics of Responsibility. The core of this theory is that one can provide reasons for their decisions and that one accepts responsibility for these decisions.²⁰⁴ Van Niekerk notes that “[w]hat can be demanded...is the full catalogue of our reasons and the arguments supporting them” (Phronesis and an ethics of responsibility, 2013:29).

As mentioned above, and as is evident from the principles themselves, Principlism allows for the interaction of many ethical standards and norms. However, Gillon (2015:2-3) suggests that the focus should be on the implementation of these principles, which would involve actually teaching and encouraging members of the medical fraternity to live by these principles.

Regrettably, in medical decisions one often does not give much consideration to the reasoning processes involved. Yet, it is these very decision-making processes that are of great importance in making the “right” decision and in subsequently being able to justify the decision made in the event that the decision made results in an undesirable outcome. These decision-making processes are informed by reason – reason that has been developed through ages of philosophical renewal. It is this reason that needs to be clearly defined.

The aforementioned schools of thought all have the capacity to influence the various components of Bioethics as stated in the Belmont Report and developed by Beauchamp and Childress. To this end the following section will attempt to provide methods for tailoring Principlism in an effort to best serve the health care user and health care provider. To this end it is worth considering the procedure to be followed when respect for autonomy is of no help, as put forward by Rakotsoane and van Niekerk (2017:260):

²⁰⁴ (Phronesis and an ethics of responsibility, 2013:28) “...we argue that individuals are accountable to the unconditional claim that others make on them, to (i) be available to others and (ii) to have their interest at heart, irrespective of whether others act reciprocally...”

“In such situations, what is needed is a principle that does not only respect self-determination or autonomy, but also and primarily respects patients as persons so that even those who lack self-determination, for one reason or another, can still be treated as having unconditional value by virtue of simply being persons. In other words, the principle of human life invaluableness is one of the principles that has the capacity to respect not only patients with the capacity to exercise their human autonomy, but all patients as persons with dignity. The principle gives the patient’s life the kind of respect that is independent of one’s personal moral status and/or state of mind or level of educational enlightenment. This is because this principle teaches, as its basic tenet, that human life can neither be compromised nor be exchanged for anything where there are competing needs. The “invaluableness” attached to the principle simply means that no value, whether monetary or otherwise, can equal the value of human life, medically speaking.”

Fadare and Jemolohun (2012:99) confirm that in many developing countries decision-making is still to some extent communal/family-based. Rakotsoane and van Niekerk (2017:259) state that the human life invaluableness principle could be utilised in circumstances in which adhering to respect for autonomy could be difficult. When one considers the person subject to this “communal autonomy” the authors (2012:99) concede that the question becomes “how well do these people actually protect the patient’s ‘best interests’”.

3.9. Resolving ethical dilemmas

The following guideline sets out the proposed method for utilising the aforementioned moral theories within the legal framework. However, it must be mentioned that this chapter cannot operate in isolation of the legislative frame work, so this section will cater for the ethicists and be the lens through which one may interpret the legal sections to follow.

The proposed framework will be an amalgamation of the most appropriate models and concepts. The overall model is adapted as follows.

3.10. Informed decision-making

As discussed in the Belmont Report, a crucial component of the decision-making process is the importance of information. Issues surrounding the processing of information are highlighted by Beauchamp & Childress (2013:134), where the authors share their concerns surrounding information overloads as well as the manner in which information is framed. The authors should be commended in their statement that what is required is better communication techniques for the profession which forms part of the concern regarding virtues instead of principles as mentioned above (Beauchamp & Childress 2013:135).

What the health care user and decision maker chose to do with the information is as important as the nature of the information provided. Problems of nonacceptance and false belief may lead to the situation in which:

“A breakdown in a person’s ability to accept information as true or untainted...can compromise decision making. A single false belief can invalidate a patient’s or subject’s consent, even when there has been a suitable disclosure and comprehension... [a]s long as this patient continues to hold a false belief that is material to her decision, her refusal is not informed refusal.” (Beauchamp & Childress (2013:136).”

Beauchamp & Childress (2013:154) set out the rules specifying the Principle of Non-maleficence. The authors acknowledge that Non-maleficence requires, *inter alia*, obligations not to impose risks of harm and that the standard, morally and legally, by which this is measured is that of Due Care (Beauchamp & Childress 2013:154). Here the thesis agrees in that there needs to be proportionality between the seriousness of the emergency and that of the risk.

The statement that negligence is the absence of due care is rather problematic, as the two situations it applies to are uncomfortably narrow in that they disqualify one from proving extenuating circumstances. However, Beauchamp & Childress (2013:154) do recognise this and note that there may be conditions, which mitigate the blameworthiness.

When dealing with the distinctions and rules governing nontreatment, Beauchamp & Childress (2013:158) state that although the distinctions have been useful they are outdated and need to be replaced. One can only agree with this finding.

What clearly flows from this is an interesting discussion on sustenance technologies²⁰⁵ and medical treatments. Beauchamp & Childress (2013:164) state that:

“No morally relevant difference exists between the various life-sustaining technologies, and the right to refuse medical treatment for oneself or others is not contingent on the type of treatment.”

In their dealing with the, admittedly legally dominated question, of intended effects and merely foreseen effects, the authors discuss the Doctrine of Double Effect.²⁰⁶ They admit to the problematic conception of intention.²⁰⁷ Given the authors views on this issue it should be acknowledged that our legal system has developed numerous degrees of intent, all of which could be of use in interpreting actions within our ethical domain. Beauchamp & Childress (2013:168) conclude by stating that instead of abandoning the concept all together, one should be aware that Doctrine of Double Effect “focuses on the way actions display a person’s motives and character”. The question here then becomes if one’s motives and character can indeed be inferred from an action. This would be interesting if an ethics of responsibility was adopted as it assumes good behaviour/intent regardless of the outcome.

In distinguishing the rules of Beneficence from the rules of Non-maleficence the authors argue that the rules are indeed quite different. Beauchamp & Childress (2013:205) make a well-reasoned distinction between general and specific beneficence making it easy to agree with the authors that there are indeed limits on sacrifice and over demanding. Specific beneficence is very similar to feminist

²⁰⁵ Beauchamp & Childress (2013:163) note that “some argue that technologies for dispensing sustenance...are nonmedical means of maintaining life that are unlike optional forms of medical life-sustaining technologies”.

²⁰⁶ Beauchamp & Childress (2013:164-5) note that this principle is generally invoked in the justification that an act with a good and bad effect is not always morally prohibited. The authors note that in order for this justification to hold the following conditions need to be met, namely: the nature of the act; the agent’s intention; the distinction between means and effect; and the proportionality between the good effect and the bad effect.

²⁰⁷ Beauchamp & Childress (2013:166) “For an action to be intentional, it must correspond to the agent’s plan for its performance”.

approaches to ethics where general beneficence is directed beyond special relationships to all persons – all of which reaffirms the notion that Principlism is a theory capable of incorporating the best of other theories.

One can appreciate the authors approach to a prima facie obligation to rescue someone in the absence of a special relationship (Beauchamp & Childress 2013:206). The implementation of guiding considerations is very useful, however, the law is clear on this issue and one is left wondering which is the better answer. Furthermore, Gillon (2015:4) concludes that it cannot be possible to benefit everyone who can be possibly benefitted, and as such the notion is limited to being an “imperfect obligation”. A health care provider’s adherence to an oath is not to be mingled with their adherence to an ethical basis.

Beauchamp & Childress (2013:215) recognise that in all decisions concerning the good of another there is the potential for Paternalism and that Medical Paternalism is still realised through the use of information and disclosure parameters (Beauchamp & Childress 2013:216). Beauchamp & Childress (2013:217) provide a detailed guide as to the nature and content of soft and hard paternalism. This should be considered in assisting with right reasoning in the treatment of minors.

Beauchamp & Childress (2013:219) caution that the problem with paternalistic policies is that the nature of the machine allows for non-inclusion of stake holders and may very well be subject to abuse if not publicly scrutinised, which could become even more problematic when the policy deals with social norms and stigmatisation. It is easy to agree with Beauchamp & Childress (2013:219) in that “[w]hile stigmatization can change behaviour, in some contexts, it often has psychological costs...stigmatizing conduct may slide into stigmatizing people who engage in that conduct”. Here minors are stigmatised as being incompetent or unable and parents are deemed to be capable.

Beauchamp & Childress (2013:225) state that a “passive paternalism occurs when professionals refuse, for reasons of beneficence, to execute a patient’s positive preferences for an intervention”.

By way of introduction the Beauchamp & Childress (2013:250) suggest that when evaluating the concept and principle of justice that “[n]o single moral principle is capable of addressing all problems of justice”. However, this doesn’t mean we must stop refining the concepts and principles.

They further state that the formal principle of justice requires that we all be equals (Beauchamp & Childress 2013:250). However, one needs to be mindful of section 36 of the Constitution which allows for the infringement of rights and fostering of inequality – when it is justifiable to do so on the predefined grounds and in accordance with precedent.

3.11. Conclusion

It becomes clear that the best interests of the minor health care user, be they informed by Principlism or any other prevailing theory of ethics, is the guiding factor in achieving a morally right outcome in the treatment of a minor health care user. When viewed through the varying philosophies, in particular that of ubuntu as discussed above and in the respective texts, it becomes clear that structures are indeed in place to not only achieve the most morally right outcome but to do so in a manner that encourages growth and development within the socio-cultural landscape.

CHAPTER FOUR

The legal world of children

“Children are happy because they don’t have a file in their minds called ‘All the Things That Could Go Wrong’”. – Marianne Williamson

4.1. Introduction

This chapter will consider the relevant legal aspects as they relate to minors. At the onset the aim of this endeavour into legal discourse is to build upon, if possible, a legal perspective of the definition proffered by Ganya et al (2016:7) that a “child has sufficient maturity to consent to medical treatment insofar as he or she can independently demonstrate (or be facilitated either by aids or a helper as far as it is practically possible in that given setting to possess) the commensurate wherewithal required to assume responsibility for that specific decision”.

Any law student will be alive to the various sources of law in South Africa namely: common law; customary law; statutory law; and the Constitution²⁰⁸. Although the Constitution is technically a statute, in that it is legislation passed by Parliament, it is the source of law against which all the others are to be measured. But these are not wholly independent from the world and it is with this in mind that the Chapter that follows explores the law as it relates to minors.

The chapter will begin by providing a brief summary of the international and regional legal landscape as it relates to the rights of children and will then proceed with an evaluation of the national instruments that govern domestic treatment of children. This will thus begin with an examination of the United Nations and move on to the African Union and culminate in South African legal instruments and interpretations. At all times the interplay between the international and the national will be noted as well as the benefits and shortfalls that are provided for within the South African landscape.

²⁰⁸ Singh (2017:131-132) confirm this taxonomy of legal sources.

In respect of the South African landscape this chapter will begin by providing an overview of the Constitution and the relevant provisions housed therein and will then deal with various other legal instruments, such as the Children's Act²⁰⁹ and the National Health Act²¹⁰, and a consideration of the relevant case law whilst culminating with an evaluation of the rules that regulate the conduct of health professionals as noted in the Health Professionals Council of South Africa.

More specifically though, the notion of rights as housed in the various instruments are of relevance as the South African legal landscape is not only founded on rights but ebbs and flows as a direct result of the enforcement and non-enforcement thereof. In line with the course adopted in previous chapters the chapter will end by providing support for the definition or by amending it. The final chapter will then incorporate the necessary aspects in an effort to prove the definition, mentioned above, proffered by Ganya et al, as being the most prudent course in line with the ethical and development aspects mentioned in previous chapters.

4.2. International Legal Instruments

4.2.1. The Universal Declaration of Human Rights

Similarly, to the Nuremberg Code the Universal Declaration of Human Rights²¹¹, herein after referred to as the “**UDHR**”, arose out of the horrors of the Second World War to address the balance of power going into a new and less hostile future. The UDHR has become the bedrock upon which rights were, and continue to be, afforded to individuals and groups. The UDHR is of particular relevance as a point of departure in the codification of the rights that apply to all human beings.

²⁰⁹ Republic of South Africa. 2005. The Children's Act 38 of 2005. Available: <http://www.lawsouthafrica.up.ac.za/index.php/current-legislation>

²¹⁰ Republic of South Africa. 2003. The National Health Act 61 of 2003. Available: <http://www.lawsouthafrica.up.ac.za/index.php/current-legislation>

²¹¹ United Nations. 1948. General Assembly resolution 217 A (III) of 10 December 1948. Universal Declaration of Human Rights.

The applicable provisions are noted herein below with special mention given to the provisions that are useful in understanding the development of the definition in question.

Article	Content
1	Deals with inherent right to equality.
3	Everyone has the right to life, liberty and security of person.
5	No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
7	States that all are equal before the law and are entitled without any discrimination to equal protection of the law.
16	States that all are entitled to marriage and that the family unit is entitled to protection.
18	States that everyone has the right to freedom of thought and conscience.
19	States that everyone has the right to freedom of opinion and expression.
25	States that everyone has the right to a standard of living.
26	States that everyone has the right to education.
29	States that everyone has duties to the community in which alone the free and full development of their personality is possible.

In light of the overall aim of this thesis as well as the theme of the chapter is it crucial that emphasis is given to the following provisions.

Article 3 states that everyone has the right to life, liberty and security of person, which is a right that has a direct bearing on medical treatments and surgeries. In respect of Article 7 it is worth noting that the greatest difference in our domestic legal system is that one can be discriminated against as long as the grounds are fair. Article 16(3) states that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 19 also recognises that this right includes the freedom to seek, receive and impart information and ideas.

Article 25(1) states that the standard of living must be adequate for the health and well-being of one and one's family which includes food, clothing, housing and medical care as well as other necessary social services.

Article 26(2) states that education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. Furthermore, education shall promote understanding, tolerance and friendship among all nations, racial or religious groups.

Article 29(1) states that everyone has duties to the community in which alone the free and full development of their personality is possible. The rights and freedoms herein are limited only by laws and may not be exercised contrary to the spirit of the UDHR. Of interest, but outside of the scope of this thesis, would be considering what impact this would have on Ubuntu and how to deal with actors in society.

In summary, the UDHR sets out the innate rights inherent to every individual and accordingly sets the foundation for how individuals are to be treated and how they are to treat others. The rights that have been codified by the UDHR have allowed for the furtherance of rights-based approaches in both the ethical and legal spheres and have been utilised in the creation of entire democracies. Thus, the UDHR, along with certain other key instruments, forms the springboard for any action concerning a human being.

4.2.2. The Convention on the Rights of the Child

The next instrument under consideration pertains particularly to children and their rights and responsibilities. The Convention on the Rights of the Child²¹² was passed by General Assembly resolution 44/25 of 20 November 1989, herein after referred to as the "**CRC**".

²¹² United Nations. 1989. General Assembly resolution 44/25 of 20 November 1989. Convention on the Rights of the Child.

It must be noted that the CRC "guarantees children the three P's: protection from maltreatment, neglect, exploitation; provision of food, healthcare, education, social security; and participation in all matters concerning them."²¹³ These very provisions require that children be protected and promoted but at the same time that they are allowed to participate and that participation has been considered not only by ethicists but legal theorists as well.

Herein below the author will provide a summary of the relevant provisions.

Article	Content
1	Deals with the age of majority and sets it at a default of 18 years of age.
2	States that parties shall ensure the protection of the rights of the child as set out in the Convention.
3	States that in any action taken in respect of the Child or in accordance with their rights the Child's interests are paramount and that the State, parents and institutions need to provide adequate protection.
6	States that the Child has the inherent right to life and that survival and development should be ensured.
9	States that the Child may not be separated from their family without the intervention of the relevant authorities or judicial decisions and where consideration is given to the Child's input.
12	States that the Child who is capable of expressing views has the right to do so.
13	States that the Child has the right to freedom of expression.
14	States that the Child has the right to freedom thought, conscience and religion.
24	States that the Child has the right to enjoy the highest attainable standard of health.
27	States that the Child has the right to a standard of living.
28	States that the Child has the right to education.
36	States that the Child is protected against all other forms of discrimination prejudicial to the Child's welfare.

²¹³ Kling and Kruger (2017:216).

In light of the overall aim of this thesis as well as the theme of the chapter is it crucial that emphasis is given to the following provisions.

Article 1 notes that “child” is defined as being every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier. It must be noted that under South African law, majority is attained at eighteen in accordance with the section 17 of the Children’s Act.

Article 2(2) of the CRC states that state parties “shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of status, activities, expressed opinions, or beliefs of the child’s parents, legal guardians, or family members”. Article 3(1) states that “[i]n all actions concerning children...the best interests of the child shall be a primary consideration.” This is the best interests standard and made its way into our domestic law, through the Constitution and the Children’s Act.

Article 6(1) places the requirement on state parties to “recognize that every child has the inherent right to life.” Of interest is what forms the content of the right and if it hinges on quality of life arguments. Furthermore, item 2 recognises that state parties “shall ensure to the maximum extent possible the survival and development of the child”. It is arguable that the two are so closely entwined that the wording is apt but what is pertinent to the content of this work is the question of whether development requires recognition.

Article 9 deals with the situations in which children may be separated from their parents against their will. In South Africa, the Courts are the upper guardians²¹⁴ of children and

²¹⁴ In *B v B* 2008 (4) SA 535 (W) it was held that the Court had the power to annul an interim protection order granted. In *Vista University, Bloemfontein Campus v Student Representative Council, Vista University, and Others* 1998 (4) SA 102 (O) the Court was cited as a respondent in an urgent application which was brought by minor students. In *Botes v Daly and Another* 1976 (2) SA 215 (N) the extent of the Court’s powers in this regard were noted. In *Godbeer v Godbeer* 2000 (3) SA 976 (W) it was noted that while the Court as the upper guardian did have the power to override a decision by a custodian parent, such power did not allow the Court to impose its own subjective whims on the children in question. Furthermore, the Court was to exercise such power only after careful consideration of all the circumstances, including reasons for the custodian parent’s decision and emotions and impulses contributing thereto.

as such third parties do have the right to supersede a child's decision makers in certain situations.

Article 12 deals with autonomy with item 1 stating that age and maturity should be considerations in weighting a child's decision making, however, the proviso is that they must be capable of doing so. Item 2 states that for this purpose a child has standing. This is an important development and is dealt with more comprehensively in the section dealing with the requirements of consent.

Article 14(1) states that state parties "shall respect the right of the child to freedom of thought, conscience and religion", which may lead one to infer that the child is capable of making informed decisions and as such has the requisite autonomy.

Article 24 (1) places the duty on state parties to "recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and that they shall "strive to ensure that no child is deprived of his or her right of access to such health care services". Of consideration is the question of whether or not this "access" has the same limitations as it does in our Constitution as it has been interpreted as only being applicable in so far as resource availability permits. On particular importance in light of the adherence to cultural practices within the South African context is the content of item 3 mandates that state parties "shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".

Article 27 deals with a child's standard of living in that state parties are now obliged to "recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development".

In summary, the CRC has provided us with the international community's minimum requirements in respect of how one is to engage with and care for children. This minimum has been expanded upon and interpreted to suit regional and national needs. The CRC has in essence given children a voice that wards off those that seek to harm and assists those that seek to help.

4.3. Regional Legal Instruments

As South Africa forms an integral part of the African continent the regional instruments are of great importance. The African Union is the umbrella organisation for the majority of the continent's countries and as such is a good place to start in determining the legal view held most widely across Africa's borders, peoples and cultures.

4.3.1. African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child²¹⁵ entered into force on the 29th of November 1999.

Article	Content
2	Defines child as every human being below the age of eighteen.
3	Every child has the right to enjoy the rights and freedoms housed herein.
4	If a child can voice their opinion, then it must be taken into account in legal and administrative proceedings.
5	Right to life.
7	Freedom of expression. Subject to being capable to do so.
9	Freedom of thought, conscience and religion.
10	Right to privacy.
11	Every child has the right to an education, to develop his or her personality, talents and mental and physical abilities to their fullest potential.
14	Every child has the right to enjoy the best attainable state of physical, mental and spiritual health.
16	Children should be protected from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse.
18	Families are the natural unit and basis for society, and should enjoy special protection.

²¹⁵ The African Union. The African Charter on the Rights and Welfare of the Child CAB/LEG/24.9/49 (1990). Available: <https://au.int/en/documents/30913/african-charter-rights-and-welfare-child-acrwc>

20	Parents or other persons responsible for the child should always act in the best interest of the child.
21	Governments should do what they can to stop harmful social and cultural practices, such as child marriage, that affect the welfare and dignity of children.
31	Children have responsibilities towards their families and societies, to respect their parents, superiors and elders, to preserve and strengthen African cultural values in their relation with other members of their communities.

It should be noted that in terms of Article 11 education also includes the preservation and strengthening of positive African morals, traditional values and cultures.

In summary, the Charter seeks to bring the provisions of the various international instruments concerning children to the regional level and in so doing tailor it to a diverse set of cultural and geopolitical identities.

4.3.2. African Youth Charter

The African Youth Charter²¹⁶, herein after referred to as the “**Youth Charter**” was passed by the African Union in Banjul on 2 July 2006. The relevant provisions within the Youth Charter will now be discussed.

The Youth Charter defines “minors” as young people between the ages of fifteen and seventeen and that for the purposes of the Youth Charter, youth or young people refers to every person between the ages of fifteen and thirty-five years.

Article	Contents
2	Non-discrimination
4	Freedom of expression
8	Protection of the Family.

²¹⁶ The African Union. The African Youth Charter. Available: <https://au.int/en/documents/30922/african-youth-charter>

10	Development.
11	Youth Participation.
13	Education and Skills Development.
16	Health.
20	Youth and Culture.
23	Girls and Young Women.
24	Mentally and Physically Challenged Youth.
25	Elimination of Harmful Social and Cultural Practices.
26	Responsibilities of Youth.

The first part of the Youth Charter deals with Rights and Duties with Article 4 recognising the content of Freedom of Expression. If one considers that “young” people shall be allowed to express their ideas and opinions freely subject to the prescribed laws it can only bode well for recognition and development of capacity and that the age distinction of fifteen to seventeen in this regard does show that there is some wiggle room.

Given the importance placed on the family unit we can only look at the meaningful ways in which it has and can be developed under the protection afforded in Article 8.

In terms of Article 10 it is worth noting that when one considers the rights listed therein that one would need to reconsider the manner in which youth are treated. This is reaffirmed by the content of Article 11(1) states that every “young person shall have the right to participate in all spheres of society”. It is noteworthy that there is no catch all here and simply just the provision that youth need to have the right to participate – not a right subject to access either, but a right.

Article 16(1) states that all youth have the right to “enjoy the best attainable state of physical, mental and spiritual health”. It is worthwhile to note that the term that needs to be unpacked is “best attainable” at which point the question then becomes whether this places the right purely in the hands of the youth and thus it is not subject to interference from others or if the rest of the world has a duty not to interfere with the enjoyment and realisation.

Article 20(1)(a) places a duty on state parties to promote and protect the morals and traditional values recognised by the community by eliminating all traditional practices that undermine the physical integrity and dignity of women. One would do well to consider what is meant by “traditional practices” and if in the context of South Africa whether the common law equates to a traditional practice. In other words, do law and ethics equate to traditional practice?

With reference to Article 25 it is perhaps preferable that one unpack what social and cultural practices actually encompass, as all that we believe and the manner in which we act on these beliefs could arguably fall within here.

Article 26 states that youths shall have the duty to, inter alia, become the custodians of their own development, partake fully in citizenship duties including voting, decision making and governance and espouse an honest work ethic whilst rejecting and exposing corruption. All these responsibilities clearly give the notion that youth are far more than the historic notions we have of them.

In summary, the Youth Charter creates an overlap between minors and young adults who to some extent not only require further opportunities to grow and develop but to do so with a certain degree of protection and preference. The Youth Charter thus solidifies the notion that all minors do not lack capacity and competency and furthermore that some adults do indeed require further assistance in developing capacity and competency.

4.3.3. Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa

As a result of practices detrimental to women it is crucial that one consider the provisions of the Protocol to the African Charter on Human and Peoples’ Rights of

Women in Africa²¹⁷, passed by the African Union in Maputo on 11 July 2003, herein after referred to the “**Protocol on Women**”. The Protocol on Women includes girls.

Article	Contents
1	Definitions.
2	Elimination of Discrimination Against Women.
3	Right to Dignity.
4	The Rights to Life, Integrity and Security of Person.
5	Elimination of Harmful Practices.
8	Access to Justice and Equal Protection before the Law.
10	Right to Peace.
12	Right to Education and Training.
13	Economic and Social Welfare Rights.
14	Health and Reproductive Rights.
17	Right to Positive Cultural Context.
18	Right to Healthy and Sustainable Environment.
19	Right to Sustainable Development.

The Protocol on Women defines discrimination against women as “any distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life”.

Furthermore, the Protocol on Women describes harmful practices as “all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity”. Lastly, the Protocol on Women defines violence against women as:

“all acts perpetrated against women which cause or could cause them physical, sexual, psychological, and economic harm, including the threat to take such acts; or to undertake the imposition of arbitrary restrictions on or deprivation of

²¹⁷ The African Union. The Protocol to the African Charter on Human and People’s Rights of Women in Africa. <https://au.int/en/documents/30920/protocol-african-charter-human-and-peoples-rights-rights-women-africa>

fundamental freedoms in private or public life in peace time and during situations of armed conflicts or of war”.

Article 3 states that in respect to the Right to Dignity and states that “[e]very woman shall have the right to respect as a person and to the free development of her personality”. Furthermore, Article 4(1) notes that in respect to Rights to Life, Integrity and Security of Person that “[e]very woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman or degrading punishment and treatment shall be prohibited”. Item 4(2)(c) places an obligation on all state parties to take appropriate and effective measures to identify the cause and consequences of violence against women and take appropriate measures to prevent and eliminate such violence”.

As a result of the views held of women, in particular within the developing world, there is a very real need to acknowledge that women of all ages are inherently vulnerable as a result of these views and that they need to be protected accordingly. Our very own law enforced the notion of a perpetual minor as far as women in traditional environments were concerned. It is for this very reason that women under the age of eighteen need to be afforded equal protection and consideration.

4.4. National Instruments

The international and regional instruments note the minimum that is expected of South Africa in how South Africa acts towards children. The thesis will now highlight what South Africa has added to the content of the abovementioned rights. It should be noted that since the birth of democracy, South Africa’s legal system has seen great change and as a result it is best to start with the source of that change. In light of this change it is hopeful to assume that the definition may be given the room it needs to grow and participate in.

4.4.1. The Constitution

The Constitution is deemed to be the supreme law of the land.²¹⁸ Chapter 2 of the Constitution houses the Bill of Rights which notes all the Rights afforded to citizens and non-citizens alike.

Article	Content
7	Rights.
8	Application.
9	Equality.
10	Human Dignity.
11	Life.
12	Freedom and security of the person.
14	Privacy.
15	Freedom of religion, belief and opinion.
16	Freedom of expression.
24	Environment.
26	Housing.
27	Health care, food, water and social welfare.
28	Children.
29	Education.
30	Language and culture.
31	Cultural, religious and linguistic communities.
32	Access to information.
33	Just administrative action.
34	Access to courts.
35	Arrested, detained and accused persons.
36	Limitation of rights.
38	Enforcement of rights.
39	Interpretation of Bill of rights.

²¹⁸ The Constitution of the Republic of South Africa, Act 108 of 1996 notes in section 2 that the Constitution is the supreme law of the land.

Section 8 deals with the Application of rights in the Bill of Rights and notes that the Bill of Rights applies to all law and binds all organs of State which is important as all outcomes will be guided by the content of the Bill of Rights. Furthermore, the Bill of Rights applies to all natural and juristic persons in so far as it is applicable in light of the relevant right. A court, when applying any provision in terms of a right, “in order to give effect to a right in the Bill, must apply, or if necessary develop, the common law to the extent that legislation does not give effect to that right”.

Section 9(1) states that everyone is equal before the law and has the right to equal protection and benefit of the law. Furthermore, subsection 3 states that the State may not discriminate unfairly against anyone on the grounds of, *inter alia*, age. Subsection 4 states that no person may unfairly discriminate against any person on the grounds in subsection 3. Thus, read together, it becomes clear that children may not be unfairly discriminated against based on their age by anyone. Subsection 5 states that discrimination on any of the above grounds is unfair unless it is shown to be fair. It is this notion of fair discrimination that is dealt with in particular in section 36, herein below, and is of practical application in the framework to follow.

Section 12 deals with freedom and security of person. Subsection 1 provides that everyone has the right to freedom and security of person, which includes, *inter alia*, the right to be free from all forms of violence, not to be tortured and not to be treated or punished in a cruel, inhumane or degrading way. Subsection 2 further provides that everyone has the right to bodily and psychological integrity, which include the right to make decisions concerning reproduction, security and control over their body and not to be subjected to medical or scientific experiments without their consent.

Section 16(1) recognises that in respect of freedom of expression that everyone has the right to freedom of expression which includes, *inter alia*, freedom to receive or impart information of ideas.

Section 28(1) states that every child has the right to, *inter alia*: family or parental care; or to appropriate alternative care when removed from their family; to basic nutrition, shelter, basic health care services and social services; and to be protected from maltreatment, neglect, abuse or degradation. Subsection 2 highlights the key

international principle of the child's best interest and that these are of paramount importance in every matter concerning the child. Subsection 3 concludes in that a child is anyone under the age of eighteen years of age.

Kling and Kruger (2017:216-217) caution that of concern is that there seems to be an omission in attempting to explain the concept of "basic health care services" in more details. This problem has, however, been elaborated upon by the courts in various other contexts and it is easy to extrapolate from there what to do in the current situation.

Section 32(1) recognises that everyone has the right to access, inter alia, any information that is held by another person and that is required for the exercise or protection of any rights.

Section 34 deals with Access to Courts and states that everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.

Section 36 is of great importance as not only does it show us how to balance competing rights but it notes the relevant factors in determining whether a limitation is acceptable or not. When dealing with the enforcement of rights section 38 states that anyone listed in the section has the right to approach a competent court when alleging that a right in the Bill of Rights has been infringed or threatened, and that the court may grant appropriate relief, including a declaration of rights.

In summary, the Constitution has thus become the unit of measure against which all interactions that affect the rights of individuals and groups are to be weighed. In this weighing of cause and effect the rights are held not as absolute but rather as the measure by which the most preferable outcome is to be obtained. Thus, the rights and responsibilities of all involved in decisions affecting children need to be viewed against this measure when seeking the most legally and ethically preferable outcome.

4.4.2. The Children’s Act

The next instrument that will be considered is that of the Children’s Act 38 of 2005, herein after referred to as the “**Children’s Act**”.

The authors conclude that there was a very real need for changing the legal framework especially in regard to the changing nature of consent and child participation.²¹⁹ The Authors reaffirm the notion that the Children’s Act creates the duties to respect children’s rights, to protect children’s rights and to promote and fulfil children’s rights.²²⁰ The authors go further in that the Children’s Act is a “one-stop-shop” law that creates a legal framework that aims to guide persons in seeing that children are protected and allowed to enjoy all their rights.²²¹

Section	Content
1	Interpretation.
2	Objects of Act.
6	General principles.
7	Best interests of the child standard.
9	Bests interest of the child paramount.
10	Child participation.
11	Child with disability or chronic illness.
12	Social, cultural and religious practices.
15	Enforcement of rights.
16	Responsibility of children.
17	Age of majority.
18	Parental responsibilities and rights.
19	Parental responsibilities and rights of mothers.
20	Parental responsibilities and rights of fathers.
21	Parental responsibilities and rights of unmarried fathers.
22	Parental responsibilities and rights agreement.

²¹⁹ Jamieson & Lake (2013:13).

²²⁰ Jamieson & Lake (2013:15).

²²¹ Jamieson & Lake (2013:16).

23	Assignment of contact and care to interested person by court order.
30	Co-holders of parental responsibilities and rights.
31	Major decisions involving children.
32	Care of child by person not holding parental responsibilities and rights.
46	Orders children's court may make.
129	Consent to medical treatment and surgical operation.
130	HIV-testing.
131	HIV-testing for foster care or adoption reasons.
132	Counselling before and after HIV-testing.
133	Confidentiality of information on HIV/AIDS status of children.
134	Access to contraceptives.
150	Child in need of care and protection.
151	Removal of any child to temporary safe care by court order.
152	Removal of any child to temporary safe care without court order.
233	Consent to adoption. Noteworthy that a child older than 10 may give consent.

The relevant provisions of the Children's Act are noted and discussed herein below.

Jamieson & Lake (2013:27) suggest that the principles housed in this Act require that in any decision that affects the rights of child that, *inter alia*, children's need for development be recognised, that their dignity is respected and that they are treated fairly and equitably.²²² Furthermore, the principles state that in any matter concerning a child that the child's family should be given the opportunity to express their views and that the child should participate according to their age, maturity and stage of development.²²³

In *S v M* 2008 (3) SA 232 (CC) at paras 18 – 19 the Court held that the "fact that the best interests of the child are paramount does not mean that they are absolute. Like all rights in the Bill of Rights their operation has to take account of their relationship to

²²² Jamieson & Lake (2013:27).

²²³ Jamieson & Lake (2013:27).

other rights, which might require that their ambit be limited.”²²⁴ Thus it is clear that our courts balance competing rights when adjudicating upon enforcement issues. The authors conclude that it is the responsibility of the health care professional to determine and act in the best interests of the child.²²⁵ Thus health care providers are given the task to similarly adjudicate, in light of their experience, upon the best interests of the child.

The authors stress that when faced such an inquiry the health professional may utilise section 7 of the Children’s Act with the relevant items be listed as follows: the child’s age, maturity and stage of development; the child’s gender; the child’s physical and emotional security and his or her intellectual, emotional, social and cultural development; any disability or chronic illness; the child’s relationship with their parents, family or caregivers; the attitude of the parents, or specific parent, toward the child; the capacity of the parents, or any other caregiver, to provide for the needs of the child; the likely effect on the child of any change in the child’s circumstances; and the need to protect the child from any physical or psychological harm, or witnessing harmful behaviour towards another person.²²⁶ Given the nature of the inquiry it is suggested that health care providers apply their minds and act in pursuit of a holistic reasoned end and accordingly the conclusion reached by authors is apt. The authors conclude by noting that this assessment needs to be holistic.²²⁷

With regard to the child’s right to participate, as set out in section 10, the authors note that it is important that this participation not be viewed as removing the parent’s / surrogate’s decisions making powers but that this process simply keeps adult decision making alive and responsive to the views of the child.²²⁸ Thus the authors, rightly, state that in order to give effect to this right one needs to consider the child’s stage of development.²²⁹

²²⁴ Jamieson & Lake (2013:28).

²²⁵ Jamieson & Lake (2013:28).

²²⁶ Jamieson & Lake (2013 29).

²²⁷ Jamieson & Lake (2013:29).

²²⁸ Jamieson & Lake (2013:30).

²²⁹ Jamieson & Lake (2013 30).

The authors state that the right to health information is an essential prerequisite to meaningful child participation in decisions affecting their bodies.²³⁰

The authors confirm that the Children's Act lowered the age of consent required for medical treatment and surgical operations – which is a clear indication that the law makers themselves saw that it was time to move in line with international principles²³¹ and that we moved in line with the school of thought that children are capable. However, as put forward in Ganya et al (2016:2) the lack of certainty surrounding what constitutes the content of the definition has created the potential room necessary to grow.

Section 1 deals with Definitions, the relevant items are listed below:

- “care”, in relation to a child, includes, where appropriate... (b) safeguarding and promoting the well-being of the child; (c) protecting the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation and any other physical, emotional or moral harm or hazards; (j) generally, ensuring that the best interests of the child is the paramount concern in all matters affecting the child.
- "care-giver" means any person other than a parent or guardian, who factually cares for a child and includes: (a) a foster parent; (b) a person who cares for a child with the implied or express consent of a parent or guardian of the child; (c) a person who cares for a child whilst the child is in temporary safe care; (d) the person at the head of a child and youth care centre where a child has been placed; (e) the person at the head of a shelter; (f) a child and youth care worker who cares for a child who is without appropriate family care in the community; and (g) the child at the head of a child-headed household.
- “family member”, in relation to a child, means (a) a parent of the child; (b) any person who has parental responsibilities and rights in respect of the child; (c) a grandparent, brother, sister, uncle, aunt or cousin of the child; (d) any other person with whom the child has developed a significant relationship, based on psychological or emotional attachment, which resembles a family relationship.

²³⁰ Jamieson & Lake (2013:35).

²³¹ Jamieson & Lake (2013:37).

- “parent”, in relation to a child, includes the adoptive parent of a child, but excludes (a) the biological father of a child conceived through the rape of or incest with the child’s mother; (b) any person who is biologically related to a child by reason only of being a gamete donor for purposes of artificial fertilisation; (c) a parent whose parental responsibilities and rights in respect of a child have been terminated.

Section 2 recognises that the Objects of the Act are to give effect to the constitutional rights of children namely, that the best interests of a child are of paramount importance in every matter concerning the child.²³² The section concludes in that the objects are generally to promote the protection, development and well-being of children.²³³

The General Principles utilised in the interpretation and application of the Children’s Act are housed in section 6 and are useful in drafting an appropriate framework. Subsection 1 notes that the provisions of the section are a guide to implementation as well as all matters concerning a child or children in general.

Subsection 2 houses what must be considered in all proceedings, actions or decision in a matter concerning a child. Subsection 3 notes that in these matters the child’s family must be afforded the opportunity to express their views.²³⁴ Subsection 4 sets out the manner in which a matter concerning a child should be resolved.²³⁵ Subsection 5 states that “[a] child, having regard to his or her age, maturity and stage of development, and a person who has parental responsibilities and rights in respect of that child, where appropriate, must be informed of any action or decision taken in a matter concerning the child which significantly affects the child”.

Section 7 deals with the Best Interest of the Child Standard and is the pivot upon which decisions concerning children are determined. Subsection 1 discusses what must be taken into account when one is tasked when considering the Best Interest of the Child Standard with subsection 7(1)(a) stating that one must consider the nature of the

²³² Section 2(b)(iv). Subsection 2(f) notes that the objects include protecting children from discrimination, exploitation and any other physical, emotional or moral harm or hazards.

²³³ Section 2(i).

²³⁴ It must be noted that there is a very real difference between affording someone the opportunity to express their views and being expected to adhere to their views.

²³⁵ The Children’s Act requires a problem-solving approach so there is room to move and not a confrontational or straight yes/ no outcome and that a delay should be avoided in so far as possible.

relationship. Subsection 7(1)(b) suggests that one must consider the attitudes of the parents in respect of the child as well as the exercise of rights and responsibilities. Subsection 7(1)(c) deals with the capacity of the person. Subsection 7(1)(g) states the child's (i) age, maturity and stage of development; (ii) gender; (iii) background; and (iv) any other relevant characteristics of the child. This subsection is of particular importance as it places the rights in the hands of the child.

Subsection 7(1)(h) recognises the physical and emotional security and his or her intellectual, emotional, social and cultural development. Subsection 7(1)(l) confirms the need to protect the child from any physical or psychological harm that may be caused by (i) subjecting the child to harmful behaviour or (ii) exposing others to the child's behaviour. Subsection 7(1)(m) notes any family violence involving the child or a family member of the child. Subsection 7(2) recognises that "parent", in relation to this section, includes any person who has parental responsibilities and rights in respect of a child.

Section 9 reaffirms the importance of section 7 by stating that the Best Interests of the Child is paramount. In all matters concerning the care, protection and well-being of a child the standard that the child's best interest is of paramount importance, must be applied.

Section 10 gives standing to the concept of child participation. Every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning that child has the right to participate in an appropriate way. Consequently, views expressed by the child must be given due consideration.

Jamieson & Lake (2013:18) state that in terms of the right to participate, that the child be listened to and be taken seriously and that the point of departure is whether the child is capable of expressing a view. They further conclude that a few implications flow from this allowance and that the first implication is that all children are capable of forming a view and that a child's view cannot simply be dismissed as a result of

youth.²³⁶ The second implication is that all children are entitled to views on all matters affecting them and that this is best articulated through consultation with the child.²³⁷ The third implication is that all children are entitled to have their views given due regard, which Jamieson & Lake (2013:20) note does not create an obligation to always adhere to the child's wishes but to consider them. The fourth implication is that the weight given to a child's views will depend on his or her age, maturity and level of understanding which creates an onus on the health professional to support the child in building capacity and competence.²³⁸

Section 11 deals with children with disability or chronic illness. Subsection 3 suggests that a "child with a disability or chronic illness has the right not to be subjected to medical, social, cultural or religious practices that are detrimental to his or her health, well-being or dignity".

Section 12 houses children's rights with regard to social, cultural and religious practices. Subsection 1 records that every "child has the right not to be subjected to social, cultural and religious practices which are detrimental to his or her well-being.

Section 13 states children's rights in terms of access to information on health care. Subsection 2 notes that "[i]nformation provided to children in terms of this subsection must be relevant and must be in a format accessible to children, giving due consideration to the needs of disabled children".

Section 15 provides detail on the enforcement of rights. Subsection 1 notes that anyone listed in this section may approach a competent court. Subsection 2(a) concludes that a child who is affected by or involved in the matter to be adjudicated may approach the court.

²³⁶ Jamieson & Lake (2013:18).

²³⁷ Jamieson & Lake (2013:19). Furthermore, the authors note the following benefits to consultation: makes the child feel more respected; relieves anxieties and helps them better cope with treatment; gives them confidence; encourages co-operation; avoids unnecessary distress; and thus, children develop a better understanding of their own health care needs and are better able to take responsibility for their own health.

²³⁸ Jamieson & Lake (2013:20).

Section 18 sets out the parental responsibilities and rights. Subsection 2 set out that parental responsibilities and rights that a person may have in respect of a child, include the responsibility and the right, inter alia, to care for the child.

Section 30 contains the rights and responsibilities of co-holders of parental responsibilities and rights. Subsection 2 notes that “[w]hen more than one person holds the same parental responsibilities and rights in respect of a child, each of the co-holders may act without the consent of the other co-holder or holders when exercising those responsibilities and rights, except where this ACT, any other law or an order of court provides otherwise”.

Section 31 details what constitutes major decisions involving children. Subsection 1(a) recognises autonomy by stating that a person must “give due consideration to any views and wishes expressed by the child, bearing in mind the child’s age, maturity and stage of development”. Subsection 1(b)(iv) notes that the above section includes any decision “which is likely to significantly change, or to have an adverse effect on, the child’s living conditions, education, health, personal relations with a parent or family member or, generally, the child’s well-being”.

Section 32 deals with care of the child by a person not holding parental responsibilities and rights. Subsection 2 provides that “[s]ubject to section 129, a person referred to in subsection (1) may exercise any parental responsibilities and rights reasonably necessary to comply with subsection (1), including the right to consent to any medical examination or treatment of the child if such consent cannot reasonably be obtained from the parent or guardian of the child”.

Section 129 is the legal bedrock upon which the definition proffered by Ganya et al will be built as it not only allows for but necessitates the development that this thesis seeks to undertake. In terms of section 129 a child may consent to medical treatment if they are over the age of 12 years and if the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.²³⁹ Furthermore, a child may consent to a surgical operation if the child is

²³⁹ Jamieson & Lake (2013:37).

above the age of 12 years and the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment and the child is duly assisted by his or her parent or guardian.²⁴⁰ Of import is that, as Jamieson & Lake (2013:37) point out, the lack of respective definitions in the Act. However, treatment would refer to “non-invasive and innocuous” procedures, while surgical operation refers to “invasive surgical interventions”.

With regard to general examinations the authors submit that the omission in the Children’s Act in this regard should not be seen as removing consent as consent is the key criterion in any examination.²⁴¹ It should be remembered with respect to surgical treatment, and in light of the aforementioned chapters, that the argument to be made is that the age of 12 should potentially be utilised as a minimum standard in the event that the child is not sufficiently mature. Thus, the provision should instead read “is of sufficient maturity or is over the age of 12 and is duly assisted by his or her parent or guardian”. At all times both the minor and their guardian need to possess the mental capacity to understand the benefits, risks, social or other implications associated with medical treatment. In the event that the guardian is found to be of insufficient maturity, in the case of a minor, or lacking the requisite faculties to consent as an adult then the relevant legal provisions need to be adhered to. This argument will be developed in the chapter to follow.

With respect to the content of assistance by a parent or guardian the forms attached to Regulation 48 give a useful guideline in acting in the appropriate manner.²⁴²

In attempting to determine if a child is sufficiently mature the authors note that the Department of Health’s guidelines state that:²⁴³

“A child is considered to be sufficiently mature if they can demonstrate that they understand information on HIV testing and can act in accordance with that appreciation. In deciding whether a child is sufficiently mature, factors that should be taken into account include:

²⁴⁰ Jamieson & Lake (2013:37).

²⁴¹ Jamieson & Lake (2013:38).

²⁴² Jamieson & Lake (2013:38).

²⁴³ Jamieson & Lake (2013:39-40).

Age: the older the child the more likely it is that they will have sufficient maturity;
Knowledge: children with knowledge of HIV and its implications are more likely to understand its consequences;
Views: children who are able to articulate their views on HIV testing and whether it is in their best interests are likely to meet the maturity requirements;
and
Personal circumstances: an assessment of the child's personal situation and their motivations for HIV testing may help in assessing their maturity.”

With respect to disclosure of the child's HIV status the authors confirm the child's right to freedom of choice is not absolute and can be limited in certain circumstances.²⁴⁴ Section 133 of the Children's Act sets out the exceptions that relate to strict observance of confidentiality in regard to the child's HIV status. The authors, however, do caution that the consequence of breaching this confidentiality could be imprisonment for up to 10 years.²⁴⁵ The authors conclude by noting that if the child unreasonably refuses to disclose their status that the health professional may then either approach the superintendent or the court.²⁴⁶

In regard to contraception section 134 of the Children's Act contains that no one may refuse a child above the age of 12 years' access to condoms. Furthermore, access to contraceptives, the Children's Act states that no one may deprive a child older than 12 years, after having received proper medical advice and the medical examination has been carried out to determine if contraceptives will not be detrimental. The authors confirm that breaches in regard to the above may meet the sanction of 10 years' imprisonment.²⁴⁷

In summary, the Children's Act sets out the rights of children as well as the duties that those that care for them need to adhere to in respect of adhering to the child's best interests and to the interests of a society that will require level headed and whole individuals in the future.

²⁴⁴ Jamieson & Lake (2013:40).

²⁴⁵ Jamieson & Lake (2013:41).

²⁴⁶ Jamieson & Lake (2013:41).

²⁴⁷ Jamieson & Lake (2013:42).

4.4.3. The Choice of Termination of Pregnancy

In regard to termination of pregnancy, section 5 of the Choice of Termination of Pregnancy Act²⁴⁸ states that any woman can consent to termination. In *Christian Lawyer Association v Minister of Health and Others* 2005 (1) SA 509 T it is noted that the “capacity to consent depends on the ability to form an intelligent will on the basis of an appreciation of the nature and consequences of the act consented to.” Furthermore, it is noted that this will require that health professionals individually assess each child’s ability and that their judgment should be guided by the best interest of the child.²⁴⁹

4.4.4. The National Health Act

The National Health Act²⁵⁰, herein after referred to as the “**NHA**”, deals with all issues of health and is applicable as it deals with the relationship between the health care practitioner and the user.

Section	Content
1	Definitions.
2	Objects of the Act.
5	Emergency treatment.
6	User to have full knowledge.
7	Consent of user.
8	Participation in decisions.
9	Health service without consent.
14	Confidentially.
15	Access to health records.
16	Access to health records by health care provider.
19	Duties of users.

²⁴⁸ Republic of South Africa. The Choice of Termination of Pregnancy Act 92 of 1996. Available: <http://www.lawsouthafrica.up.ac.za/index.php/current-legislation>

²⁴⁹ Jamieson & Lake (2013:43).

²⁵⁰ Republic of South Africa. The National Health Act 61 of 2003. Available: <http://www.lawsouthafrica.up.ac.za/index.php/current-legislation>

20	Rights of healthcare personnel.
55	Removal of tissue, blood, blood products or gametes from living persons.

Section 1 deals with Definitions, with the relevant provisions highlighted herein below:

“rehabilitation” means a goal-orientated and time-limited process aimed at enabling impaired persons to reach an optimum mental, physical or social functional level;

“user” means the person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is...”

Of particular import is Chapter 2 of the NHA which deals with the rights and duties of users and health care personnel. Section 5 states that emergency treatment may not be refused to anyone who requires it. Thus, regardless of whether or not it is in the interests of the child an emergency treatment may not be refused. Furthermore, section 6 states that the user is to have full knowledge. This is a crucial component of informed consent. Section 6 (1) of the NHA states that there exists a duty on the part of the provider to inform the user.

Section 6(2) takes this further in stressing the language to be used in this action. Singh (2017:139-140) note that the exception to informed consent is therapeutic privilege which is reflected in section 6(1) of the NHA which recognises that a user must be informed 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”. Furthermore, section 8(3) notes that consent need not be informed if it is not in the best interests of the patient.

Section 7 deals with the importance attached to the consent of the user. It provides that subject to section 8 a health service may not be provided to a user without the user's informed consent. Further section 7(1) of the National Health Act states that “a health care provider must take all reasonable steps to obtain the user's informed consent”. Subsection 3 defines informed consent as “consent for the provision of a

specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6”.

Section 8 deals with the importance of user participation in decision making. Subsection 8(2)(b) makes provision that if a user lacks legal capacity but is capable of understanding then they are to be informed as required in section 6. Section 9 deals with instances in which a health service can be obtained without consent.

Section 14 deals with issues of Confidentiality. Subsection 1 notes that all information is confidential. Subsection 2 notes, that subject to section 15, no information may be disclosed unless there is prior consent, a court or law requires it or public health is at stake.

Section 15 deals with access to health records. Subsection 1 notes that the requirement for disclosure is “any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user”.

In summary, the NHA sets out not only the rights duties of users and health care providers but the framework by which their interactions are to be governed and regulated. The NHA is of great import as it provides greater understanding into what the nature of consent is as it is required in engagements of a medical nature.

4.5. Conclusion

It is thus clear that the legal instruments provide the parameters by which the interactions with children are governed. There has been a shift in doing away with an approach in which age was the only consideration and moving toward an approach that has seen individuals given more freedom to participate through the recognition of their mental and emotional faculties. This recognition seems to have progressed simultaneously with legal principles and assumptions found in one of the of the most utilised fields of law, being the law of contract.

Singh (2017:133) note that the doctor-patient relationship is contractual in nature with an implied agreement between the doctor and the patient. This then takes the relationship out of the realm of purely ethical and into a hybrid of law and ethics. Breach of this contract results from a failure to adhere to the patient's wishes – which, arguably involves their desires and best interests. Singh (2017:133-135) further note that the doctor owes the patient a duty of care as a result of the contract.

The following chapter will seek to provide greater clarity as to what is meant by informed consent from both an ethical and legal interplay before utilising the information contained herein to formulate an appropriate framework in which to treat minors ethically within the parameters of the law.

CHAPTER FIVE

Sufficient Maturity and Informed Consent: What has been learnt from what has come before and what can be done with that knowledge

“Health professionals need to listen to children, provide appropriate information and give them time to articulate their concerns, so that children can develop the confidence and ability to contribute effectively to their own health care.”²⁵¹

5.1 Introduction

The purpose of this chapter is to combine the ethical and legal interpretations of sufficient maturity, as guided by informed consent and the Best Interests of the patient. The chapter will seek to combine the varying principles into a useable concept that would aid in support of the definition proposed by Ganya et al (2016:05):

“A child has sufficient maturity to consent to medical treatment insofar as he or she can independently demonstrate (or be facilitated either by aids or a helper as far as it is practically possible in that given setting to possess) the commensurate wherewithal required to assume responsibility for that specific decision.”

It has been submitted that a relevant part of determining maturity is that of mental capacity. Havenga and Temane (2016:43) suggest that mental capacity can be referred to as decisional capacity which is the “ability to understand relevant information, appreciate the situation and its consequences, and reason for treatment options” as well as the ability to communicate the choice.²⁵² This view is not only considered in the previous chapters but is reiterated by Havenga & Temane (2016:43) in that a child is sufficiently mature if the child can “demonstrate they understand information on HIV testing and can act in accordance with that appreciation”.²⁵³

As one of the purposes of this thesis is to develop and build upon the Ganya et al definition it is proffered, in light of the above, that the definition be accompanied by the

²⁵¹ Jamieson & Lake (2013:44).

²⁵² Havenga & Temane (2016:43) note that decisional capacity exists when people not “only have the simple ability to understand, but must actually grasp the purpose of the intervention, the consequences of consent or refusal, the alternatives, and the magnitude and probabilities of harm and benefit.”

²⁵³ National Department of Health’s HIV Counselling and Testing (HCT) Policy guidelines

proviso that the Patient is considered to have taken responsibility through understanding and reasoning of the information provided as well as the potential consequences thereof. This proviso would be informed by no small part by the content of this thesis and in particular the Framework noted in Chapter 6.

The chapter will thus begin by considering the principle of Best Interests as it finds applicability in the current frameworks before evaluating sufficient maturity in a similar vein. The chapter will culminate by putting forward a guide as well as a list of the key provisions utilised in the formation thereof.

5.2 The concept of “Best Interests”

At the onset, it cannot be ignored that there are in essence two sets of Best Interests at play, notably the Best Interests of the child as well as the Best Interests of the patient, both of which arise from different guidelines but that overlap in the particular instant where children become the patient. It is therefore crucial to note that the invisible hand throughout the chapter is the notion that the Best Interests ultimately influence the decision-making process and thereby greatly affect the outcome of the individual processes and thus the final outcome of whether or not to proceed with the medical intervention.

As alluded to in previous chapters, a child’s capacity for understanding has always been the determining factor in their recognition as autonomous decision-makers.²⁵⁴ This recognition of autonomy forms an integral part of the Best Interests of the child but it is not the only consideration as often it is “not always obvious in any given situation what the best interests of the child are”²⁵⁵. The concept has its roots in international instruments, as noted in Chapter 4, and has been adopted into national law through the section 28(2) of the Constitution as well as the Children’s Act.

The problem would seem to be in interpreting the principle’s content which has given rise to healthy debate with it being deemed to mean the “highest net benefit among

²⁵⁴ Kling and Kruger (2017:217).

²⁵⁵ Kling and Kruger (2017:218).

the available options that apply to any situation in which a decision has to be made regarding the health of the child"²⁵⁶. This interpretation leads one to conclude that it is thus a quality of life concern.

In an effort to reach the appropriate outcome one should also consider factors such as:

- the child's ability to participate in any decision-making; the views of the parents and family;
- the implications of treating or not treating the patient;
- the effectiveness and side effects of the treatment; and
- the risks from delayed treatment or nontreatment.

Section 7 of the Children's Act states that when considering the best interests of the child one should consider such factors as: age; maturity and stage of development; gender; background; physical and emotional security; intellectual, emotional and cultural development; disability; chronic illness; need for protection and parents' attitude and capacity.

This view has been criticised as being too unrealistic but Kopelman (1997,2007) "argues that it does not require what is ideal but what is reasonable, given the available options. In other words, it should also take into account the needs and rights of others." It is important to note that the assessment of Best Interests "must take into account the physical, emotional, social, cultural and psychological needs of the person"²⁵⁷ as no child is an island.

At this junction it is worth being reminded that given the assumptions surrounding a child's development that it is easier to accept the weight attached to Best Interests. A statement that becomes more inescapable when one notes after discussion with the child, that they possess the capacity to appreciate their decisions and thus are sufficiently mature and have the capacity to provide consent in the appropriate circumstances.

²⁵⁶ Kling and Kruger (2017:218).

²⁵⁷ Kling and Kruger (2017:218).

The thesis will now consider the practical application of the elements such as disclosure of information and consent. It must be noted that sufficient maturity would contribute toward the determination of informed consent.

5.3. Informed Consent and Disclosure of Information

There are various components that need to be considered when making a determination in respect of consent. Beauchamp & Childress (2013:124) argue that there are two sets of elements that constitute informed consent but prefer, and I agree with them in their preference, that it consists of: Competence; Disclosure; Understanding; Voluntariness; and Consent.

However, as a result of the patients in question it would seem that, all things being equal, that the main considerations in determining informed consent would be the aspects of competence, understanding and consent, and accordingly these will be given the most coverage. At this stage then, the aforementioned aspects in the legal, ethical and psychological chapters will be brought to bear.

The following factors have been utilised as a springboard for informing the interactions between the Health Care Provider and the patient when assessing a child's capacity to consent:²⁵⁸

“1. Reasoning

- i. Age
- ii. IQ
- iii. Cognitive functioning
- iv. Emotional functioning

2. Understanding

- i. Experiential factors (what the child has experienced previously)
- ii. Knowledge of the problem

3. Voluntariness

- i. Uncoerced patient decision (valid consent requires freedom of choice)

²⁵⁸ Kling and Kruger (2017:223-224). Havenga and Temane (2016:44) note that mental capacity is contingent upon: understanding the relevant information; reason about treatment options; and appreciation of the situation and consequences; and the ability to communicate the choice.

4. The nature of the decision to be made

- i. Gravity (e.g. having an intravenous line put up as compared with major surgery)
- ii. Urgency of the decision (emergency treatment)
- iii. Risk-benefit balance.”

This is supported by Havenga and Temane (2016:44) in that there has been a shift in international thinking that no longer focuses on age but on the unique circumstances of each child, which is influenced by their experience and understanding. The abovementioned can be assigned to the following terms of the definition:

- Commensurate wherewithal refers to a means required for a specific purpose and that in the present instance the means would include cognitive and emotional faculties.
- Assuming responsibility would refer to an understanding as only when one has understanding can one fully assume responsibility.
- The specific decision would refer to the nature of the decision to be made.
- Lastly, however, one cannot directly compare the issue of voluntariness with that of independently demonstrate. It should be noted that independently demonstrate would in the present instance refer to a sufficient level of assistance offered to the child throughout the process.

In Chapter 4 the legal requirements as they related to the treatment of minors were dealt with. In Chapter 2, the actual and no longer perceived capacities of a child were set out and thus create a degree of uncertainty as to the general approach adopted by legal authors. This chapter will be dedicated to explaining these legal requirements in greater detail and perhaps more importantly tempering them with ethical considerations.

5.3.1. Capacity and Competency as elements of Sufficient Maturity

It is clear that competence and capacity seem to form the basis of consent.²⁵⁹ This consent may come in the form of express or tacit consent, depending on the nature of the treatment. An important element in this process is the Health Care Provider whose duty it is to ensure that consent is obtained from a patient before any examination or treatment.²⁶⁰

With regard to Sufficient Maturity the question then becomes how the Health Care Provider assess children's capacity and the answer seems to require determining if the child has "full knowledge of the procedure, and understands the nature of the risk of the treatment or surgery".²⁶¹ This determination seems to form part of the definition with regard to assuming responsibility and commensurate wherewithal.

Determining maturity can be both challenging and time consuming²⁶² as there seems to be a deafening silence in the various pieces of legislation and regulations.²⁶³ In respect of determining maturity it must be stated, and as was confirmed in chapter 2, that a child's capacities are highly dependent on their life experiences²⁶⁴, as "[w]hen children are given appropriate support, adequate information and opportunities to express themselves meaningfully...all children can participate in clarifying and resolving issues that are important to them".²⁶⁵

To this end it is worth being reminded that children are constantly "evolving in their cognitive ability and therefor have evolving capacity to develop autonomy" and that in "the case of children who are not yet competent to decide for themselves, the 'best interests standard' is applied".²⁶⁶ One could arguably simply exchange competence

²⁵⁹ Beauchamp & Childress (2013:117-9) The authors focus on standards of incompetence as opposed to competence. Although the tests are indeed empirical, each one is underlined by normative judgments.

²⁶⁰ Singh (2017:136).

²⁶¹ Jamieson & Lake (2013:44).

²⁶² Havenga & Temane (2016:43).

²⁶³ Jamieson & Lake (2013:44).

²⁶⁴ Jamieson & Lake (2013:43).

²⁶⁵ Jamieson & Lake (2013:43).

²⁶⁶ Kling and Kruger (201:217).

for maturity and thus a patient would be entitled to decide if being deemed to be sufficiently mature.

Chapter 2 further highlighted the importance of education as a factor of a child's development and thus sufficient maturity. In accordance with the foregoing, if education is pursued the outcomes for society would include: treating children as individuals with different capacities; increasing access to healthcare services; making sure older children are not unnecessarily burdened in the event that they cannot cope; and encouraging children to take responsibility for their own health care and thus greater adherence to the system.²⁶⁷

Jamieson & Lake (2013:20) point out that the international law principle requiring that a child's evolving capacities need to be respected, has similarly interesting implications. They note, and this confirms the development theories explored in chapter 2, that as children grow and develop they require less adult direction and supervision as they develop a greater capacity to take responsibility for their lives.²⁶⁸ Furthermore, Jamieson & Lake (2013:20) note that the CRC recognises that these capacities develop at different ages in accordance with environmental and individual factors.²⁶⁹

Jamieson & Lake (2013:21) caution that the continual use of minimum age requirements is not entirely in line with this principle, as was noted above with regard to the commencement of adolescence, and that attempts at rectifying this discrepancy are made by lowering these very limits, within acceptable parameters. One such parameter is that of sufficient maturity.

It cannot be overstated that the assessment of a child's capacity should preferably be conducted by a person with the requisite skills and training,²⁷⁰ but only in so far as

²⁶⁷ Jamieson & Lake (2013:44).

²⁶⁸ Jamieson & Lake (2013:20).

²⁶⁹ Jamieson & Lake (2013:20) "The concept of evolving capacities is central in achieving a balance between recognising children right to be listened to and granted increasing autonomy, and recognising their right to protection and support in accordance with their relative immaturity and youth. 'This concept provides the basis for an appropriate respect for children's agency without exposing them prematurely to the full responsibilities normally associated with adulthood.'"

²⁷⁰ Jamieson & Lake (2013:21).

establishing a base line with respect to the complexity of the decision. This determination will most likely require evaluating the minor's response to the disclosure of the information presented in terms of their understanding and ultimately consent thereto. As per Chapter 2, children have developed the necessary faculties to engage with information and to interpret same through cognitive processing.

5.3.2. Disclosure as an element of Sufficient Maturity

In their evaluation of disclosure, Beauchamp & Childress (2013:125) explain that informed consent has its origins in a legal context but note that "from the moral viewpoint...it has little to do with the liability of professionals as agents of disclosure and everything to do with autonomous choices of patients and subjects". It is for this very reason, that for the purposes of this thesis, that sufficient maturity is a prerequisite for informed consent for minors between the ages of 12 and 18.

Furthermore, it is noted that the Health Care Provider has a duty to inform the patient about material and remote risks, with a material risk being present if "(a) a reasonable person in the position of the patient would, when warned of the risk, attach significance to it; and (b) a medical practitioner is reasonably aware that the [patient], if warned of the risk, would attach significance to it".²⁷¹ At this point it should be noted that the Health Care Provider need not provide an exhaustive list to the patient but should provide a minimum amount which is pertinent to the treatment,²⁷² which would prevent an information overload but also prevent paternalism from preventing the patient from having material information, so long as it is in their Best Interests.

Disclosure requires an interaction between the Health Care Provider and the patient and this interaction is a key component as this disclosure would set the stage to test the patient's understanding, reasoning and ultimately sufficient maturity.

²⁷¹ Singh (2017:138).

²⁷² Singh (2017:138) confirms this view.

5.3.3 Sufficient Maturity as a pre-requisite of Consent

As mentioned previously herein the National Health Act outlines the legal requirements for consent. It must be noted that sections 6, 7 and 8 have been considered by our courts. In *Castell v De Greef* 1994 (4) SA 408 (C) the Court set out the requirements that need to be met if informed consent is deemed to be present, which has been reaffirmed by *Sibisi NO v Maitin* 2014 (6) SA 533 (SCA). The Courts have held that the requirements of informed consent are that the patient must: have knowledge of the nature or extent of the harm or risk about to be entered into; appreciate and understand the nature of the harm or risk about to be entered into; consent to harm or assume the risk.

This interplay between knowledge and an appreciation of the position that the patient finds themselves in, closely resembles the content of sufficient maturity and can thus be applied in those situations as additional tools of interpretation or guiding factors. The literature further requires that the consent must be “comprehensive and extend to the entire transaction, inclusive of the consequences”²⁷³, which reads similar to the definition proposed by Ganya et al. What is of import here is that the existence of sufficient maturity will allow the child to provide consent. Accordingly, sufficient maturity will always be a consideration in the determination of consent as without it there can be no consent.

Section 129(3) of the Children’s Act deals with surgical treatment and states that the child may only consent if they meet the requirements set out in section 129(2) and are duly assisted by their parent(s) or guardian(s). This becomes problematic in a society in which adults themselves, arguably, lack the requisite education and development to make an informed decision. This becomes increasingly problematic when one considers the requirements placed on adults in subsections 129(4) and (5).

Furthermore, the legal authority to provide consent is not automatically available to certain parties. Biological fathers, for instance, are only able to provide consent on

²⁷³ Singh (2017:138) This view has further been confirmed by both Griffith (2016) as well as Havenga and Temane (2016).

behalf of their children, if the requirements set out in sections 20 and 21, as they relate to married and unmarried biological fathers, are considered.

Section 129 (9) states that a High Court may consent to medical treatment or a surgical procedure in the event that the other person cannot. It is worth noting that this is already codified in terms of common law in terms of which the Courts are considered to be the upper guardians all children. Section 129(10) prohibits parental refusal on the grounds of religious belief unless they could show that there is a medically accepted alternative to the proposed course of action.

Section 32(1) of the Children's Act sets out how a person who has no parental responsibilities and rights may be allowed to provide consent. It is worth noting that the requirements come as a result of caring and providing for the child. It is further noted that this is still subject to the provisions of section 129.

The route taken in determining which law applies will start with the interpretation of the relevant legislation with the focus being placed on the autonomy of children and specifically on the interplay with other parties' rights.

5.4. Children and Consent: Ethics.

Kling and Kruger (2017:222) set out the concern that Bioethics is still dominated by "outdated age-stage theories of child development" which tend to overemphasize a child's "ignorance, inexperience, and inability to make truly informed autonomous decisions, as if the mind and conscience grow as slowly as the body." The emphasis should instead rest on the ability of all the participants and should result in the Best Interests of the patient being the standard. This is confirmed in chapters 3 and 4.

This is in line with CRC and in particular Article 12 which recognises that children should be involved in decision making and implies that we have an obligation to respect a child's decision.²⁷⁴ This recognition receives further support when one considers the various ages at which children are allowed to engage in legally

²⁷⁴ Kling and Kruger (2017:222).

recognised endeavours e.g. the witnessing of a will, or signing a contract, or being emancipated. Furthermore, research has shown that children wish to be informed even if that information is painful, which reaffirms the notion that “the child is a subject of rights, not merely a beneficiary of adult good will and as such must be included as an actor in the decision making process”.²⁷⁵

Kling and Kruger (2017:223) submit that the prerequisites for informed decision-making as being a child “who possesses a stable value system, and has the ability to understand the information relevant to the decision(s), to deliberate the consequences of the options, and to make decisions that reflect his or her own value system has the capacity for decision making”. This echoes the stages of development discussed in the section dealing with adolescents in Chapter 2. It should not be forgotten that adolescents are deemed to have developed the requisite competencies and capacities to meet these requirements.

Griffith (2016:244) refer to the Gillick principle which recognises “that a child under 16 had the legal competence to consent to medical examination and treatment if they had sufficient maturity and intelligence to understand the nature and the implications of the treatment.” Griffith (2016:245) reaffirms that the test is whether a child has the ability to understand and that where there is a choice to be made that the child accepts that choices have consequences and are “willing, able and mature enough to make that choice.” The concern here is simply that if this is not part of the medical, and more importantly legal culture in South Africa, that it is perhaps best that we incorporate this in developing a technique that is uniquely suited to our context.

Griffith (2016:245) further adds that when a child has been deemed to be Gillick Competent that the child can consent to treatment, however, in the event that the child refuses lifesaving treatment that the child may be overridden by a person who may provide consent ordinarily.

²⁷⁵ Kling and Kruger (2017:222) confirms the view held by Lansdown (2000).

Familial context should never be disregarded but should be weighted accordingly.²⁷⁶ This importance was mentioned in chapter 2 noting the value of family and culture on development and in chapter 4 when the legal acknowledgement was noted. In considering the role of family and community, especially within the cultural contexts of many southern African environments²⁷⁷, the theory of Ubuntu may find some applicability in the present instance. The theory notes that:

“Ubuntu is ‘humanness’...Umuntu ngumuntu ngabantu means that ‘it is through others that one attains selfhood’...One cannot exist as a human being in isolation. We are linked to others and what we do influences others as well. Mkhize (2006) argues that, although it would seem that involving the family or community in consent for treatment for an individual violates the principle of autonomy, in fact it shows a higher level of respect because one is showing respect for the traditions and culture of the patient’s community.”²⁷⁸

This is perfectly acceptable as long as this respect for the school of cultural relativism does not infringe upon the individual’s Best Interests. One should always be mindful of value systems but should never let them supersede common sense and good.²⁷⁹

5.5. Children and Consent: The Law

In regard to the Children’s Act one needs to be aware of section 10 which notes that “[e]very child that is of such 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.” Once again, the age under consideration is 12, the maturity needs to be sufficient and that this is informed by development stages.

²⁷⁶ Kling and Kruger (2017:223).

²⁷⁷ Ellis (2017:56) reminds us that the in many African and indigenous communities worldwide people “consult the ancestors and forefathers...and also defer to a traditional healer to seek guidance in their consent deliberations”.

²⁷⁸ Kling and Kruger (2017:227).

²⁷⁹ To this end it is worth noting the view held by the Constitutional Court in the matter of *City of Tshwane Metropolitan Municipality v Afriforum and Another* (157/15) [2016] ZACC 19 (21 July 2016), in that although one needs to give a voice to the theory it must not be interpreted in such a fashion as to alienate and disregard other theories in their entirety.

Section 129 deals with consent and it is the silence with which certain aspects are dealt with that has necessitated elaboration and development of the mute concepts. It should be further noted that the legislation is equally silent on what constitutes the respective treatments. As noted herein the thesis suggests that complexity, novelty and degree of risk should be determining factors and not whether the classification is that of treatment or surgery.

Kling and Kruger (2017:226) note that the concept of maturity refers to a child's developmental level and that this should be viewed in line with the theme that this sort of evaluation is archaic as it focuses on the child's presumed ignorance. However, given that the content of chapter 2 and the move away from such archaic views it would seem that maturity is now becoming the platform upon which minors' autonomy is recognised.

In instances where the child refuses to give consent, if the child has the requisite capacity then one needs to consider the reasonableness of the child's refusal by either approaching the Minister of Social Development or the courts.²⁸⁰ If a child lacks capacity to consent then the health professional will be in acting in accordance with the law should they adhere to the decision of the requisite surrogate decision maker.²⁸¹

In the case of a medical emergency²⁸² the superintendent can consent on behalf of the child but only in circumstances where the treatment or surgery is needed to save the child's life or prevent serious physical injury or disability and it is so urgent that there is not enough time to obtain the necessary consent from the person who is authorised to consent.²⁸³

The Children's Act Guide for Health Care Providers²⁸⁴ brings some interesting points to the discussion as well as highlighting the pivotal basics. For instance, Jamieson and Lake (2016:7-9) provide some practical examples of the definitions of import in the

²⁸⁰ Jamieson & Lake (2013:51).

²⁸¹ Jamieson & Lake (2013:51).

²⁸² Jamieson & Lake (2013:57) notes that an emergency is borne out of necessity and urgency.

²⁸³ Jamieson & Lake (2013:56).

²⁸⁴ Jamieson & Lake (2013).

Children's Act i.e. caregiver and the person who has rights and responsibilities in respect of the child.

With regard to the right to information that the Health Care Provider plays a greater role in realising this right.²⁸⁵ Havenga and Temane (2016:44-45) note that not only is the manner in which information is given is crucial²⁸⁶, but that parental involvement is important as well.²⁸⁷ It is as a result of these rights and responsibilities that the Health Care Provider now has a duty to meaningfully engage and consult with the child and their caregiver.²⁸⁸

5.6. The Health Care Professions Council of South Africa Guidelines.

When dealing with the Health Care Provider it is worth noting that they are bound by not only the laws the of Republic but by the HPCSA's ethical rules, at section 10.3, binds professionals registered to its boards. However, this is a minimum and the material will improve upon it incorporating both advancements in ethics and legal developments.

5.6.1. Booklet 1: General Ethical Guidelines for the Health Care Professions²⁸⁹

Section 2 deals with the core ethical values and standards for good practice and notes at subsection 2.3 that the core ethical values and standards required of health care practitioners include, inter alia:

- respect for persons; best interests or well-being (non-maleficence);
- best interests or well-being (beneficence);
- human rights; autonomy; community.

²⁸⁵ Jamieson & Lake (2013:21).

²⁸⁶ Jamieson & Lake (2013:21) The authors note that information must be provided in an age appropriate manner with regard to language. Furthermore, it should be given to the child by someone they know and trust and that in making the child feel safe one should afford them the opportunity to ask questions.

²⁸⁷ Jamieson & Lake (2013:22).

²⁸⁸ Jamieson & Lake (2013:22).

²⁸⁹ Health Professions Council of South Africa (2016:Booklet 1).

This reaffirms the notion that Principlism is the guiding factor in the interactions between providers and users. This does not detract from the values of compassion and justice, the latter referred to in previous chapters.

Section 3 sets out a guideline in how to resolve ethical dilemmas and highlights the values that Health Care Providers need to consider. Subsection 3.3 states that ethical reasoning proceeds in 4 steps, namely:

- formulating the problem;
- gathering information;
- considering options; and
- making a moral assessment.

The final step requires considering the answers to certain questions. This reasoning process informed the process that was considered in the formulation of the proposed guideline.

Section 5 considers the duties to patients with subsection 5.1 “Patient’s best interests or well-being” providing a list of things to be done by Health Care Practitioners in their interactions with patients. Item 5.1.5 for instance notes that no personal beliefs, e.g. age and competence, should prejudice a patient’s treatment. This assists the guide by which patients are to be treated but may prove problematic when the Best Interests are in dispute. Item 5.1.8 states that practitioners are to “apply their mind when making diagnoses and considering appropriate treatment.”

Subsection 5.2 notes the content of respect for patients and begins by detailing the manner in which interactions with patients are to be conducted. Item 5.2.5 notes that practitioners must “[g]uard against human rights violations of [patients], and not allow, participate in or condone any actions that lead to violations of the rights of [patients]”. These rights may flow from cultural groupings as much as they do from overarching considerations.

Subsection 5.3 deals with informed consent and notes that patients be given the information that they ask for and in a manner, that is appropriate to them. Furthermore, it notes that the Health Care Provider should refrain from withholding information.

Subsection 5.5 reaffirms the concept of patient participation in their own health care and notes that a patient's full involvement in decision making should be respected "even if they are not legally competent to give the necessary consent."

5.6.2. Booklet 3: National Patient's Rights Charter²⁹⁰

The Introduction contains in section 1 that the purpose of this charter is there to give effect to the patient's rights housed in the Constitution as they relate to healthcare.

Section 2 notes that a patient's rights include, inter alia:

- a healthy and safe environment;
- participation in decision making; and
- informed consent.

Subsection 2.8 notes that in respect of informed consent that "[e]veryone has the right to be given full and accurate information about the nature of one's illness, diagnostic procedures, the proposed treatment and risks associated therewith and the costs involved." A common theme throughout which is tied into children's abilities.

5.6.3. Booklet 4: Seeking Patients' Informed Consent - The Ethical Considerations²⁹¹

Subsection 2.1 states that the relationship is one of mutual trust and that a "practitioner must respect patient's autonomy" to foster trust. It goes on to state that autonomy is a patient's "right to decide" and that patients "must be given sufficient information in a way that they can understand, to enable them to exercise their right to make informed decisions about their care".

²⁹⁰ Health Professions Council of South Africa (2016:Booklet 3).

²⁹¹ Health Professions Council of South Africa (2016:Booklet 4).

Subsection 2.2 reaffirms that informed consent is a right enjoyed by patients. Subsection 2.3 states that “[e]ffective communication is the key to enabling patients to make informed decisions”.

Of special application to the proposed guideline is Section 3 which deals with the content of consent to investigation and treatment. Subsection 3.1²⁹² begins by dealing with the requirements of sufficient information, noting in subsection 3.1.1 that “[patients] have a right to information about their condition and the treatment options available to them” and that the amount of information that must be provided will vary according to considerations such as the “nature of the condition, the complexity of the treatment, the risks associated with the treatment or procedure, and the patient’s own wishes”.

Subsection 3.1.3 notes that “[patients] have a right to information about any condition or disease from which they are suffering” and that this information should be presented in a language that the patient understands and that one be mindful of the nature of the information which the patient wants or ought to know, before they decide whether to consent to treatment or an investigation.” Subsection 3.1.4 reaffirms the requirements that in providing information, health care practitioners must endeavour to find out about the individual patient’s needs and priorities.

Subsection 3.1.5 notes that health care practitioners are not to exceed the scope of their authority and thus there must be specific consent granted. Subsection 3.1.7 notes that Health Care Practitioners should seek a patient’s consent to treat any problems which may arise as well as note any procedures to which the patient would object, or prefer to be given further thought to before they proceed.

Subsection 3.2²⁹³ deals with the manner in which Health Care Practitioners are to respond to questions and notes that any questions raised, should as far as possible, be met with an honest answer that further the user’s wishes.

²⁹² This is would arguably form part of the requirement that you explained it in simple language and in simple terms.

²⁹³ This would once again see if it was sufficiently explained to the patient.

Section 3.3 states that Health Care Practitioners should not withhold information necessary to the decision-making process unless they determine that the disclosure would cause the patient serious harm. Subsection 3.3.2 notes that precedent requires informing the patient of all “material risks”.

Section 3.4 notes the manner and form that presenting information to users is to take and recommends that Health Care Practitioners should discuss treatment options “at a time when the user is best able to understand and retain information.”

Section 5 states the right of patients to information making reference to the National Health Act and the nature of information to be forthcoming to patients.

Section 6 states the importance of ensuring voluntary decision-making and notes that it is for the patient to determine what is in their Best Interests. Subsection 7.3 notes that pressure may be put on patients from a myriad of sources but that Health Care Practitioners should do their best to ensure that patients have considered the options and reached their own decision.

Section 7 deals with the process to be followed in emergencies.

Section 8 provides guidelines on establishing a patient’s capacity to make decisions. Subsection 8.5 deals with Children with subsection 8.5.1 noting that Health Care Providers must assess the child’s capacity to decide, in re a proposed investigation or treatment. Subsection 8.5.2 states that “a competent child will be able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment.”

Subsection 8.5.3 notes that the following must be considered: age of majority; children 12 years of age; and children under 12 years of age.

Section 9 provides further clarity on the Best Interests Principle with subsection 9.1 setting out what needs to be considered when dealing with options concerning patients who lack the requisite capacity. Subsection 9.2 refers to the Constitution which

provides that a child's Best Interests are paramount in every matter concerning the child.

Section 16 notes the importance of reviewing consent stating that a "signed consent form is not sufficient evidence that a patient has given, or still gives, informed consent to the proposed treatment in all its aspects. Health care practitioners must review the user's decision close to the time of treatment..."

5.6.4. Booklet 5: Confidentiality – Protecting and Providing Information²⁹⁴

Section 2 – Definitions

- "Consent" in terms of the National Health Act means consent for the provision of a specified health service given by a person with legal capacity. A person older than 12 years may consent to medical and surgical treatment subject to being sufficiently mature to provide the consent. (Children's Act (Act No. 38 of 2005) and a female of any age may consent to a termination of pregnancy (Choice of Termination of Pregnancy Act (Act No. 92 of 1996)).
- "Express consent" means consent which is expressed orally or in writing (except where patients cannot write or speak, when other forms of communication may be sufficient).
- "Patients" are referred to as "users" in the National Health Act. A "user" is a person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service. It must be noted that "user" includes persons who are authorised to give consent in terms of the National Health Act where the user is incompetent to give consent.

5.7. Conclusion

It is clear that there are sufficient legal and ethical mechanisms available to assist in the treatment of minors that will not only result in the most morally correct outcome but that will see the best interests of the patient realised. However, these mechanisms require some structure and it is with this in mind that the final chapter will put forward

²⁹⁴ Health Professions Council of South Africa (2016:Booklet 5).

a framework to be utilised in the treatment of minors – a framework that will see the recognition of developmental and ethical considerations realised within the parameters of the South African legal landscape.

CHAPTER SIX

Framework for the Determination of Sufficient Maturity

6.1. Introduction

As noted in the preceding chapters there are sufficient mechanisms available to assist in the treatment of minors, but that these mechanisms are either too isolated or too complex to be of assistance at the time that the Health Care Provider is required to attend to the minor.

The framework that follows is based on the considerations found not only in bioethics²⁹⁵ but in the South African Legal landscape as well. They have been tailored to assist the determination of Sufficient Maturity and will be structured accordingly:

- the Examination;
- the Patient;
- the Intervention;
- the Decision; and
- the Outcome.

It has been noted by Kling and Kruger (2017:221) that the very laws set in place to assist children may, very well, result in more harm than good particularly as a result of the ever-increasing nature of the litigious society we live in. Arguably, this is true in a society in which legal practitioners endeavour to make the most out of their bottom line instead of pursuing the child's Best Interests. Singh (2017:150), by way of example note that the remedies available to a patient should their right to informed consent have been violated, is to lay a charge against the practitioner or to bring a civil action for invasion of privacy against the practitioner and their employer. It is for this very reason that the proposed framework formulated herein below are to be tempered by the Best Interests principle.

²⁹⁵ Moodley (2017:184-189) sets out the 5 steps in dilemma resolution as follows: Step 1: Identify and Articulate the Moral Dilemma; Step 2: Establish All the Necessary Information; Step 3: Analyse the information; Step 4: Formulate Solutions, Make Recommendations, Then Act; and Step 5: Implement Policy.

6.2. The Framework

6.2.1. Step 1: Examination.

The Examination allows the Health Care Provider the opportunity to give effect to determining aspects in respect of the patient, as noted in Step 2 below, as well gaining a better understanding of what the diagnosis will be and the possible interventions, as noted in Step 3 below. It is important that whilst the Health Care Provider examines the child that they engage in the process of anticipating what will be required of them, legally and ethically in the steps ahead.

It is worth noting that the following may all be situations that see the Patient presenting at the Health Care Provider:

- Medical treatment;
- Surgical treatment;
- HIV test;
- Termination of pregnancy;
- Request for contraception;
- Virginitiy test;
- Circumcision;
- Minor with parental responsibility for a child.

It is noted that all of these situations come with different risks and levels of complexity, and that some of them arguably overlap with the medical and surgical treatment. What should however be highlighted is that request for contraception cannot be denied after age 12 and that termination of pregnancy has no lower limit. Furthermore, the final situation may see the responsible child having the necessary maturity by virtue of their responsibility toward the child under their care. It should be noted that these special cases need to be carefully considered by the Health Care Provider upon his/her evaluation of the Patient.

6.2.2. Step 2: The Patient.

The Patient is assumed to be minor i.e. a person under the age of 18. However, as noted above one must consider if the Patient is above the age of 12 and if that is indeed the case, whether the Patient possesses Sufficient Maturity.

Thus, in line with the material and considerations noted herein above one would need to firstly determine the exact age of the minor so as to meet any legal requirements and secondly the requirement of sufficient maturity as noted herein above.

This will require engagement with the child, and their parent or guardian, to determine if in the presence of suitable assistance, the child is capable of being presented with the requisite information, understands the information and will be able to utilise reason in assuming responsibility for the decision at hand.

6.2.3. Step 3: An Intervention.

With reference to the Intervention one would need to distinguish between a general examination, a medical treatment and a medical surgery. The first category does not require great explanation and would for the purposes of the Framework constitute a procedure or an administration that is not complex nor fraught with danger performed by a Health Care Provider in the normal course of events. As noted the thesis does not agree with the distinction between medical and surgical treatment, with the latter easily being part of the former, but will utilise the distinction at present.

To this end the thesis suggests that the assumption made by Ganya et al, that medical treatment be meant to only include the consumption of medication, be extended to include any procedure that when considered holistically does not carry excessive risk or complexity. As noted by Havenga and Temane (2016:45) it is the complexity, magnitude and circumstances surrounding the diagnostic test, treatment or procedure that should require increased degrees of maturity as “[d]ifferent levels of understanding and responsibility are required for different types of treatment”. Although I am of the view that this is the most suitable approach, due to the added requirements that will be placed on Health Care Providers in this evaluation, the

following has been proffered, in line with the Children's Act, to prevent undue delay and harm.

An Intervention that involves medical treatment would require that one address the following:

- Firstly, one would need to consider what constitutes medical treatment.
- Secondly, one would need to evaluate the risk associated with the treatment.
- Thirdly, one needs to consider how these are to be interpreted in light of the desired outcome.
- Lastly, one would need to determine if the Patient meets the requirements in terms of section 129, in that they are older than 12 and have Sufficient Maturity, and if not whether there is a parent, guardian or care giver present that may legally consent to the medical treatment.

An Intervention that involves medical surgery requires that one addresses the following issues:

- Firstly, one would need to be aware of what constitutes medical surgery.
- Secondly, one would need to consider the risk associated with the surgery.
- Thirdly, one would need to determine if the Patient meets the requirements in terms of section 129, in that they are older than 12, have Sufficient Maturity and have been duly assisted by a parent or guardian. If not, then the Patient's surrogate decision makers are to intervene. Lastly, one would need to weigh these factors against the desired outcome.

6.2.4. Step 4: The Decision.

For the purposes of this Framework Sufficient Maturity is the standard to be used in determining if a decision is indeed valid. Sufficient Maturity will be determined in accordance with legal requirements as noted in the National Health Act and the Children's Act. These requirements will then be tempered with the above ethical standards and development assumptions in order to achieve a morally right outcome in the Best Interests of the Patient.

In light of these requirements one will evaluate the competency and capacity of the decision makers, being both the Patient and their surrogate decision makers. This step is ultimately a consideration of the decisions made by the Patient, those with rights and responsibilities in respect of the Patient and the Health Care Provider.

6.2.5. Step 5: The Outcome.

When a decision is made the Health Care Provider may either act in accordance with the decision if it is valid or proceed back to the respective decision-making stage.

6.3. Sufficient Maturity

In an effort to better assist in this process it is worth noting the content of sufficient maturity as derived from the preceding chapters and noted in the figure below. The content of the figure may best be elaborated upon as follows:

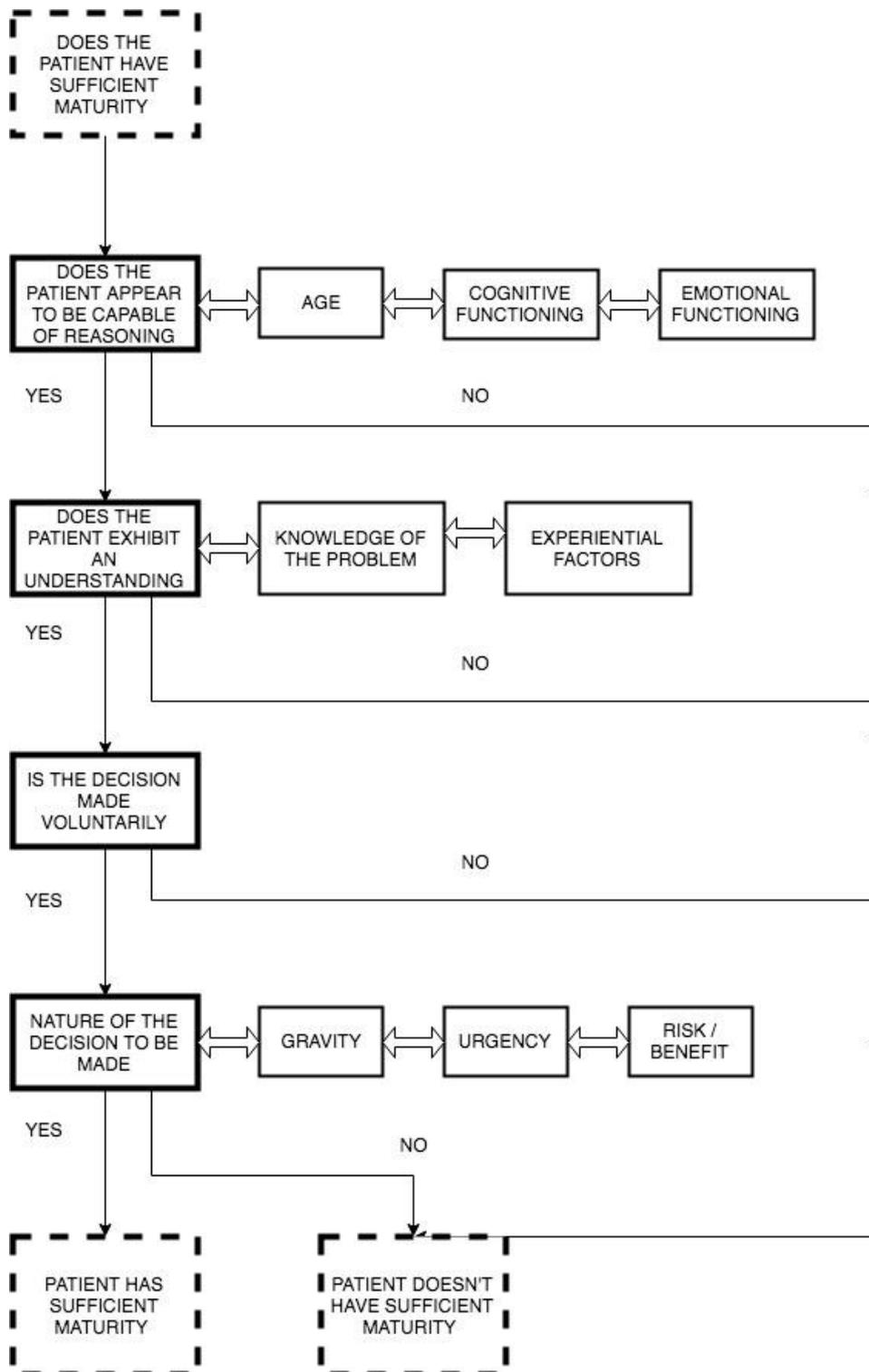
- Does the Patient appear to be capable of reasoning?
- Does the Patient exhibit an understanding?
- Is the Decision made voluntarily?
- The Nature of the Decision to be made.

With the exception of termination of pregnancy, a request for contraception and an HIV test, in so far as the latter items having a minimum floor of 12 is concerned, the majority of the situations listed in 6.2.1 above will require an affirmative answer to each stage for the evaluation if the Patient is to be deemed to have sufficient maturity.

6.4. Conclusion

It is suggested that this Framework be considered in the treatment of minors, especially as it has been compiled from fields that best speak to not only the individual but the collective as well. It is this Framework that will at worst create the necessary discussions concerning a very important part of South African society and will at most make a meaningful contribution toward the lives of those persons.

Figure 1: Flow diagram noting sufficient maturity



Bibliography

Ackerman, T.F & Strong, C. 1989. A Casebook of Medical Ethics. 1st edition. New York: Oxford University Press, 1989.

The African Union. The African Charter on the Rights and Welfare of the Child CAB/LEG/24.9/49. Available: <https://au.int/en/documents/30913/african-charter-rights-and-welfare-child-acrwc> [2017, September 3].

The African Union. The African Youth Charter. Available: <https://au.int/en/documents/30922/african-youth-charter> [2017, September 3].

The African Union. The Protocol to the African Charter on Human and People's Rights of Women in Africa. <https://au.int/en/documents/30920/protocol-african-charter-human-and-peoples-rights-rights-women-africa> [2017, September 3].

Arnett, J.J. 2004. Adolescence and emerging adulthood: A cultural approach (2nd ed.) Upper Saddle River, NJ: Prentice-Hall.

B v B 2008 (4) SA 535 (W).

Baltes, P.B. & Baltes, M. M. 1990. Successful ageing: Perspectives from the behavioural sciences. Cambridge, MA: Cambridge University Press.

Bandura, A. 2006. Towards a psychology of human agency. Perspectives on Psychological Science, 1(2): 164-180.

Beauchamp, T.L & Childress, J.F. 1983. Principles of Biomedical Ethics. 7th edition. New York: Oxford University Press, 2013.

Behrens, K.G. 2013. Towards an indigenous African bioethics. South African Journal Bioethics and Law, 1(6), June: 32-35.

Boston University. Behavioral Change Theories. Available: sphweb.bumc.bu.edu/otlt/MPM-

Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories5.html [2017, October 3]

Botes v Daly and Another 1976 (2) SA 215 (N).

Bray, R., Gooskens, I., Khan, L., Moses, S. & Seekings, J. 2010. Growing up in the new South Africa: Childhood and adolescence in post-apartheid Cape Town. Cape Town, South Africa: HSRC Press.

Bronfenbrenner, U. 1979. The ecology of human development. Cambridge, MA: Harvard University Press.

- Bronfenbrenner, U. 1995. Developmental ecology through space and time: A future perspective. In P. Moen, G.H. Elder, & K. Luscher (Eds.). Examining lives in context: Perspectives on the ecology of human development. Washington, DC: American Psychological Association.
- Castell v De Greef 1994 (4) SA 408 (C).
- Chegg. Social Cognitive Theory. Available: www.chegg.com/homework-help/definitions/social-cognitive-theory-13 [2017, October 3]
- Cherry, K. 2017. Erik Erikson's Stages of Psychosocial Development. Available: <https://www.verywell.com/erik-eriksons-stages-of-psychosocial-development-2795740> [2017, September 3].
- Cherry, K. 2017. Piaget's Theory: The 4 Stages of Cognitive Development: Background and Key Concepts of Piaget's Theory. Available: <https://www.verywell.com/piagets-stages-of-cognitive-development-2795457> [2017, September 3].
- Child Soldiers Organisation. 2017. How many children are used for military purposes worldwide? Available: <https://www.child-soldiers.org/FAQs/how-many-children-are-used-for-military-purposes-worldwide> [2017, September 3].
- Children's Institute. 2016. South African Child Gauge 2016. Available: http://www.ci.uct.ac.za/sites/default/files/image_tool/images/367/Child_Gauge/2006/Book_Child_Gauge_2016_lowres.pdf [2017, September 3].
- Children's Institute. South African Law Reform Report 2002. Available: http://www.ci.org.za/depts/ci/plr/pdf/salrc_rprt_02/pr110chapter04.pdf [2017, September 3].
- Christian Lawyer Association v Minister of Health and Others 2005 (1) SA 509 T
- City of Tshwane Metropolitan Municipality v Afriforum and Another (157/15) [2016] ZACC 19 (21 July 2016).
- Claremont Graduate University. History of Ethics. Available: <http://www.cgu.edu/pages/1722.asp> [2016, March 28].
- Department of Basic Education. 2013. General household survey 2011: Focus on schooling. Pretoria: South Africa.
- Dhai, A. 2012. A health system that violates patients' rights to access health care. South African Journal of Bioethics and Law, 1(5), June: 2-3.
- Elkind, D. 1967. Egocentrism in adolescence. Child Development, 38(4): 1025-1034.

- Elkind, D. 1985. Cognitive development and adolescent disabilities. *Journal of Adolescent Health Care*, 6(2): 84-99.
- Ellis, C. 2017. Deferential vulnerability and patient decision-making. *South African Journal of Bioethics and Law*, 10(2): 56-57.
- Erikson, E.H. 1950. *Childhood and Society*. New York, NY: Norton.
- Eze, M.O. 2008. What is African Communitarianism? Against Consensus as a regulative ideal. *The South African Journal of Philosophy*, 27(4): 386-399.
- Fadare, J.O. & Jemilohun, A.C. 2012. Discharge against medical advice: Ethical-legal implications from an African perspective. *South African Journal Bioethics and Law*, 2(5), December: 98-101.
- Freud, S. 1953-1974. *Standard Edition of the Complete Psychological Works of Sigmund Freud*. London: Hogarth Press, 2001.
- Freund, A.M., & Baltes, P. 2002. Life-management strategies of selection, optimisation and compensation: Measurement by self-report and construct validity. *Journal of Personality and Social Psychology*, 82(4): 642-662.
- Gade, C.B.N. 2011. The Historical Development of the Written Discourses on Ubuntu. *The South African Journal of Philosophy*, 30(3): 303-329.
- Gade, C.B.N. 2012. What is Ubuntu? Different Interpretations among South Africans of African Descent. *The South African Journal of Philosophy*, 31(3): 484-503.
- Gardner, H. 1983. *Frames of mind: The theory of multiple intelligences*. New York, NY: Basic Books.
- Gardner, H. 1999. *Intelligence reframed: Multiple intelligences for the 21st century*. New York, NY: Basic Books.
- Gardner, H. 2006. *Multiple intelligences: New horizons in theory and practice*. New York, NY: Basic Books.
- Ganya, W., Kling, S., Moodley, K. 2016. Autonomy of the child in the South African context: is a 12 year old of sufficient maturity to consent to medical treatment? *BMC Medical Ethics*. Available: <https://doi.org/10.1186/s12910-016-0150-0> [2016, November 2].
- Gillon, R. 2014. Defending the four principles approach as a good basis for good medical practice and therefore for good medical ethics. *Journal of medical ethics*, 41(1): 111-6.

- Ginsburg, P.G., and Opper, S. 1988. Piaget's Theory of Intellectual Development: Adolescence. E-Book 2016. Available: freepsychotherapybooks.org [2017, October 3]
- Godbeer v Godbeer 2000 (3) SA 976 (W).
- Griffith, R. 2016. What is Gillick competence? *Human Vaccines & Immunotherapeutics* 12(1), January: 244-247.
- Havenga, Y. & Temane, M.A. 2016. Consent by children: considerations when assessing maturity and mental capacity. *South African Family Practice*, 58(sup1): S43-S46. Available: <http://dx.doi.org/10.1080/20786190.2014.977058> [2017, September 3].
- Health Professions Council of South Africa. 2016. General Ethical Guidelines for the Health Care Professions: Booklet 1. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%201.pdf [2017, September 3].
- Health Professions Council of South Africa. 2016. Ethical and Professional rules of the Health Professions Council of South Africa: Booklet 2. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%202.pdf [2017, September 3].
- Health Professions Council of South Africa. 2016. National Patient's Rights Charter: Booklet 3. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%203%20.pdf [2017, September 3].
- Health Professions Council of South Africa. 2016. Seeking Patients' Informed Consent: The Ethical Considerations: Booklet 4. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%204%20.pdf [2017, September 3].
- Health Professions Council of South Africa. 2016. Confidentiality: Protecting and Providing Information: Booklet 5. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%205.pdf [2017, September 3].
- Health Professions Council of South Africa. 2016. Ethical Guidelines for Good Practice with regard to HIV: Booklet 6. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/ethical_rules/Booklet%206%20Gen.pdf [2017, September 3].

Health Professions Council of South Africa. 2016. Guidelines for the withholding and withdrawing of treatment: Booklet 7. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%207.pdf [2017, September 3].

Health Professions Council of South Africa. 2016. General Ethical Guidelines for reproductive health: Booklet 8. Available: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%208%20.pdf [2017, September 3].

Jamieson, L & Lake, L. 2013. Children's Act Guide for Health Professionals. 5th edition. Cape Town: Children's Institute, University of Cape Town, 2013. Available: <http://www.ci.org.za/depts/ci/pubs/pdf/resources/guides/2013/Childrens%20Act%20Guide%20for%20Health%20Professionals%202013.pdf>. [20 August 2016].

Lidz, T. 1974. The Life Cycle: Introduction. American Handbook of Psychiatry, (1).
Louw, D., & Louw, A. 2014. Child and Adolescent development. 2nd edition. Bloemfontein: Psychology Publications.

Khomba, J.K. 2011. Redesigning the balanced scorecard model: an African perspective. Published doctoral dissertation. University of Pretoria: UPSpace [Online]. Available: <http://hdl.handle.net/2263/28706> [2017, September 3].

Kling, S. & Kruger, M. 2017. Paediatric ethics, in K. Moodley (ed) Medical Ethics, Law and Human Rights: A South Africa Perspective. 2nd edition. Pretoria: Van Schaik Publishers, 2017. 215-236.

Kohlberg, L. 1969. Stage and sequence: The cognitive developmental approach to socialization. In D.A. Goslin (Ed.) Handbook of socialization theory and research. Chicago, IL: Rand McNally.

Kohlberg, L. 1984. Essays on moral development: The psychology of moral development. San Francisco, CA: Harper & Row.

Kohlberg, L. 1987. The Development of moral judgement and moral action. In L. Kohlberg (Ed.), Child psychology and childhood education. New York, NY: Longman.

Kopelman, L.M. 1997. The Best-Interests Standard as Threshold, Ideal, and Standard of Reasonableness. Journal of Medicine and Philosophy 22 (3):271-289.

Kopelman, L. M. 2007. The Best Interests Standard for Incompetent or Incapacitated Persons of All Ages. Journal of Law, Medicine & Ethics 35 (1):187-196.

MacWhinney, B. 2010. Language development. In M. Lamb & A Freud (Eds), Lifespan development (Vol) 1 & 2. Hoboken, NJ: John Wiley & Sons.

- Mahery, P & Proudlock, P. 2011. Legal guide to age thresholds for children and young people. 5th edition. Cape Town: Children's Institute, University of Cape Town, 2011. Available:
<http://www.ci.org.za/depts/ci/pubs/pdf/resources/guides/Ages%20Guide%20April%202011%20e-version.pdf>. [2017, September 3].
- Marcia, J. E. 1980. Identity in adolescence. In J. Adelson (Ed.), Handbook of adolescent psychology. New York, NY: Wiley.
- McCormick, T.R. University of Washington School of Medicine: Ethics in Medicine. Available: <https://depts.washington.edu/bioethx/tools/princpl.html>. [24 March 2015].
- Moloketi, G.R. 2009. Towards a common understanding of corruption in Africa. Public Policy and Administration, 24(3): 331-338.
- Moodley, K. 2007. Microbicide research in developing countries: Have we given the ethical concerns due consideration? Available: <http://www.biomedcentral.com/1472-6939/8/10.doi:10.1186/1472-6939-8-10> [2017, September 3].
- Moodley, K. 2017. Resolving ethical dilemmas: an approach to decision making, in K. Moodley (ed) Medical Ethics, Law and Human Rights: A South Africa Perspective. 2nd edition. Pretoria: Van Schaik Publishers, 2017. 183-198.
- Moodley, K et al. 2017. Medical Ethics, Law and Human Rights: A South Africa Perspective. 2nd edition. Pretoria: Van Schaik Publishers, 2017.
- Mudhovozi, P., Ramarumo, M., & Sodi, T. 2012. Adolescent sexuality and culture: South African mothers' perspective. African Sociological Review, 16 (2): 119-138.
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. Ethical Principles & Guidelines for research involving Human Subjects. Available: <https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html> [2017, September 3].
- National Department of Health. 2015. HIV Counselling and Testing (HCT) Policy guidelines. Available: <https://www.health-e.org.za/2015/07/09/guidelines-national-hiv-counselling-and-testing-hct-policy-guidelines-2015/> [2017, September 3].
- Newman, B., & Newman, P.R. 2012. Development through life: A psychological approach. Belmont, CA: Wadsworth.
- Paciello, M., Fida, R., Tramontano, C., Cole, E., & Cerniglia, L. 2013. Moral dilemma in adolescence: The role of values, prosocial moral reasoning and moral disengagement in helping decision making. European Journal of Developmental Psychology, 10(2): 190-205.

Piaget, J. 1932. *The Moral Judgment of the Child*. London: Routledge & Kegan Paul United.

Piaget, J. 1936. *Origins of intelligence in the child*. London: Routledge & Kegan Paul.

Rachels, J & Rachels, S. 2003. *The Elements of Moral Philosophy*. 7th edition. Asia: McGraw-Hill Education, 2012.

Rakotsoane, F. & van Niekerk, A. 2017. Human life invaluable: An emerging African bioethical principle. *South African Journal of Philosophy*, 36(2): 252-262. Available: <http://dx.doi.org/10.1080/02580136.2016.1223983> [2017, September 3].

Republic of South Africa. 1996. Constitution of the Republic of South Africa Act 108 of 1996. Available: <http://www.constitutionalcourt.org.za/site/theconstitution/thetext.htm> [2017, September 3].

Republic of South Africa. 1996. The Choice of Termination of Pregnancy Act 92 of 1996. Available: <http://www.lawsouthafrica.up.ac.za/index.php/current-legislation> [2017, September 3].

Republic of South Africa. 2003. National Health Act 61 of 2003. Available: https://www.acts.co.za/national_health/index.html [2017, September 3].

Republic of South Africa. 2005. Children's Act 38 of 2005. Available: <https://www.acts.co.za/childrens-act-2005/index.html> [2017, September 3].

Roazen, P. 2012. *Psychotherapy Guidebook: Eriksonian Therapy*. eBook 2016. International Psychotherapy Institute. Available: freepsychotherapybooks.org [2017, October 1].

S v M 2008 (3) SA 232 (CC).

Science Museum. Nuremberg Code. Available: <http://www.sciencemuseum.org.uk/broughttolife/techniques/nurembergcode> [2017, September 3].

Selman, R. 1976. Social Cognitive understanding: A guide to educational and clinical practices. In T. Likona (Ed.), *Moral development and behaviour: Theory, research and social issues*. New York, NY: Holt, Rinehart & Winston.

Selman, R. 1980. *The growth of interpersonal understanding: Developmental and clinical analyses*. New York, NY: Basic Books.

Shuster, E. 1997. Fifty Years Later: The Significance of the Nuremberg Code. Available: <http://www.nejm.org/doi/full/10.1056/NEJM199711133372006#t=article> [2017, September 3].

Sibisi NO v Maitin 2014 (6) SA 533 (SCA).

- Singh, J.A. 2017. Law and the health professional in South Africa, in K. Moodley (ed) Medical Ethics, Law and Human Rights: A South Africa Perspective. 2nd edition. Pretoria: Van Schaik Publishers, 2017. 129-166.
- Steinberg, L. & Cauffman, E. 1996. Maturity of judgement in adolescence: Psychological factors in adolescent decision making. *Law and Human Behaviour*, 20(3): 249-272.
- Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 50 (GP) (4 May 2015).
- Super, C.M., & Harkness, S. 1986. The development niche: A conceptualisation at the interface of the child and culture. *International Journal of Behavioural Development*, 9(4): 545-570.
- Super, C.M., & Harkness, S. 1994. The developmental niche. In *Psychology and culture*. Boston, MA: Allyn & Bacon.
- Super, C.M., & Harkness, S. 2002. Culture structures the environment for development. *Human Development*, 45(4): 270-274.
- The Basics of Philosophy (Deontology). Available: http://www.philosophybasics.com/branch_deontology.html. [24 March 2015].
- The Basics of Philosophy (Ethics). Available: http://www.philosophybasics.com/branch_ethics.html. [24 March 2015].
- The Basics of Philosophy (Utilitarianism). Available: http://www.philosophybasics.com/branch_utilitarianism.html. [24 March 2015].
- The Community Notice Board. 2017. Limpopo learners still experiencing textbook crisis. Available: <http://greatertubatsenews.co.za/2017/05/25/limpopo-learners-still-experiencing-textbook-crisis/> [2017, September 3].
- This Day in History. Available: <http://www.history.com/this-day-in-history/nuremberg-war-crimes-trials-begin> [2017, September 3].
- Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10. 1949. Vol. 2: 181-182. Washington, D.C.: U.S. Government Printing Office, 1949.
- Tutu, D. 2004. *God has a dream: a vision of hope for our future*. London: Rider.
- United Nations. 1948. General Assembly resolution 217 A (III) of 10 December 1948. Universal Declaration of Human Rights.
- United Nations. 1989. General Assembly resolution 44/25 of 20 November 1989. Convention on the Rights of the Child.

US Department of Health and Human Services. The Nuremberg Code. Available: <http://www.hhs.gov/ohrp/archive/nurcode.html> [2016, March 28]

Van Niekerk, A.A. & Nortje, N. 2013. Phronesis and an ethics of responsibility. South African Journal Bioethics and Law, 1(6), June: 28-31.

Vista University, Bloemfontein Campus v Student Representative Council, Vista University, and Others 1998 (4) SA 102 (O).

Watson, J.B. 1924. Psychology from the standpoint of a behaviorist. Philadelphia, PA: J.B. Lippencott Company.