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Ethical challenges faced by health professionals in assessing children's maturity and mental capacity to consent to medical treatment as provided for in Section 129 (2) of the Children's Act

Potjo, Mantoa Melita

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Ethical challenges faced by health professionals in assessing children's maturity and mental capacity to consent to medical treatment as provided for in Section 129 (2) of the Children's Act.

Potjo Mantoa Melita

2619177

A dissertation submitted to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg, in partial fulfilment of the degree of Master of Science in Medicine (Bioethics and Health Law).

Supervisor: Siraaj Khan

October 2025

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I Potjo Mantoa Melita

(Student number: 2619177)

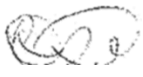
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Lastly, a special thanks to Teacher Veronica for always being available to care for my little prince while I attended my block sessions.

Dedication

This study is dedicated to my son, my little prince, Potjo Tlhohonolofatso Omolemo Bohlale. Thank you for the long nights we spent together, with you often sleeping under my desk while I worked on my studies. You would insist on staying up, telling me, “Mommy, I am your friend; I will sit with you until you are done.” We accomplished this together, buddy!

Abstract

Section 129(2) of the Children's Act allows children aged 12 and older to consent to their own medical treatment. The validity of this consent is determined by a health professional's assessment of the child's maturity and mental capacity to understand the benefits and consequences of the proposed treatment. However, there are currently no guidelines to help health professionals conduct these assessments. This paper aims to address a normative question: in the absence of clear guidelines for assessing children's maturity and mental capacity, could Section 129(2) potentially violate children's right to autonomy? I argue that without proper guidelines, there is indeed a risk of infringing on children's autonomy.

To support my argument, I present three main points: First, the competence of health professionals to assess a child's maturity and mental capacity is questionable, as the Act does not specify who should carry out these assessments. Second, there are no specific assessment tools designed for this purpose, raising concerns about the validity and reliability of any measures currently in use. Third, the Act itself is vague and ambiguous, failing to define key concepts, such as "sufficient maturity." Finally, when viewed through the lenses of Utilitarianism and Kantian deontology, Section 129(2) lacks ethical support. In conclusion, given the potential for violating children's right to autonomy, there is an ethical imperative to amend Section 129(2) of the Children's Act.

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List of Abbreviations

African Charter on the Rights and Welfare of the Child	ACRWC
American Medical Association	AMA
Children's Act 38 of 2005	CA
Child Care Act 74 of 1983	CCA
Child Justice Act 75 of 2008	CJA
Continuous Professional Development	CPD
Health Professions Council of South Africa	HPCSA
Health Professions Act 56 of 1974	HPA
National Health Act 61 of 2003	NHA
Psychological Society of South Africa	PSYSSA
Society for Industrial and Organisational Psychology of South Africa	SIOPSA
South African College of Psychology	SACAP
South African Medical Association	SAMA
United Nations Convention on the Rights of the Child	UNCRC
United Nations Children's Fund	UNICEF

CHAPTER 1

1.1. Introduction

South African law recognises that children can consent to medical treatment without their parents from age 12. However, the validity of this consent is based on the health professional's assessment of the "child's maturity and mental capacity to understand the benefits and consequences of the proposed treatment," as stated in Section 129(2) of the Children's Act 38 of 2005 (hereinafter referred to as CA). The country's legal status regarding children's rights to consent to medical treatment is in line with international standards, which recognise the evolving capacity of children to consent and participate in medical decision-making (Kruger 2018, p. 5). South African law addresses matters relating to children in the CA. Section 129(2) specifically deals with children's rights to autonomy in medical decision-making and is stated as follows:

> *"(2) A child may consent to his or her medical treatment or the medical treatment of his or her child if— (a) the child is over the age of 12 years; and (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.*
> *(3) A child may consent to the performance of a surgical operation on him or her or his or her child if— (a) the child is over the age of 12 years and (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and (c) the child is duly assisted by his or her parent or guardian".*

Section 129(2) differentiates between "medical treatment and surgical operations". The age requirement and mental capacity assessment are the same for medical treatment and surgical operations; however, parental assistance is further required for the latter. Although Section 129 is divided into two sections, my focus in this study will only be on

Section 129(2), which deals with medical treatment. I assume that whether the child needs to consent to medical treatment or a surgical operation, the same procedure of assessing mental capacity and maturity will need to be followed.

a) Legal basis of children's rights

The United Nations Convention on the Rights of the Child (hereinafter referred to as UNCRC) and the Constitution of the Republic of South Africa 108 of 1996 (hereinafter referred to as the Constitution) have influenced children's rights to self-determination. Article 12 of the UNCRC states that "children's view must be considered in all the matters concerning the child, taking into consideration the age and maturity of the child". Section 28(2) of the Constitution highlights that the "child's best interests should be of paramount importance" when directing matters affected by the child. Every child is acknowledged as a unique individual with inherent rights protected by the Constitution. Constitutional rights such as "rights to dignity, right to privacy, right to freedom of religion, expression, and association" give effect to children's autonomy rights (Kruger 2018, p. 5).

Section 129(2) hence aims to "promote children's rights and to ensure that children's views are considered in medical decision-making" (Kruger 2018, p. 2). However, I argue that this section poses ethical challenges to healthcare professionals regarding the definition of "sufficient maturity" and how this concept should be assessed. The CA does not define what constitutes maturity and how health professionals ought to assess this concept. Pillay & Singh (2017, p. 3) argue that health professionals lack consensus on conducting maturity assessments, compounded by the absence of a clear definition of

maturity. This creates an ethical challenge for health professionals as they must balance “respecting children’s autonomy and protecting their interests” (Hein et al. 2015, p. 2). It further raises ethical questions concerning competency and justice. Regarding competency, it's essential to consider if all health professionals are equally trained to conduct these assessments and if there is a common understanding of how they should be carried out. In terms of justice and fairness towards children, the question remains as to whether available assessments can be applied consistently to all children without disadvantaging any child.

b) Understanding maturity and mental capacity

Assessing children’s maturity and mental capacity is a complex and challenging task due to the multiplicity of factors influencing individuals’ decision-making. “The complexity of the information shared, the individual's cognitive ability to understand the information, the environment in which the decision-making is taking place”, and the behaviour of others (Buchanan & Brock 1990, p. 20) are the factors that influence one decision-making. In South Africa, this complexity is further exacerbated by the population diversity and lack of standardised assessment tools to measure maturity and mental capacity (Laher & Cockcroft 2013, p. 540). A country’s diverse population background plays a significant role in assessing maturity and mental capacity, as any objective assessment will have to consider individuals’ sociocultural backgrounds to guard against cultural and language bias (Laher & Cockcroft 2013, p. 540). The lack of objective assessment tools is challenging as without any standardised tools, health professionals tend to rely on

subjective assessment (Pillay & Singh 2017, p. 94), which raises significant questions relating to the validity and reliability of such measures.

1.2 Rationale of the study.

Children's ability to consent to medical treatment has been debated since the CA was promulgated in 2005 (Hein et al. 2015, p. 1; Kruger 2018, p. 2). However, Hein et al. (2015, p. 1) argue that most of the "discussion has been centred around normative concerns relating to whether 12-year-old children can consent". The focus on the normative issues relating to the appropriate age of consent has taken the focus away from the clinical issues relating to health professionals' duties in assessing the mental capacity to consent. As a result, little has been done to focus on what constitutes maturity and mental capacity and how it ought to be measured. Three fundamental questions remain unanswered regarding who should conduct maturity and mental capacity assessments, how they should be conducted, and why ensuring objective assessment of children's maturity and mental capacity is essential.

This has further delayed progress in interrogating whether Section 129(2) could potentially infringe upon children's right to autonomy. Section 129(2) stipulates that children must have sufficient maturity and mental capacity to comprehend the benefits and consequences of the proposed treatment. However, CA does not specify who should perform these assessments. Is it the responsibility of the treating health professional or mental health professionals, who are specialists in conducting mental capacity assessments? Additionally, there is a lack of consensus on which assessment measures

should be used for these evaluations. This is exacerbated by the absence of standardised assessments specifically designed for this purpose in South Africa. Consequently, there is limited data on the methods currently employed by health professionals to fulfil this requirement (Bester et al. 2018). Additionally, there is a lack of clarity concerning the terms "sufficient maturity" and "mental capacity" in the act. These terms are not explained in the CA, and no guidance is provided for health professionals to understand them (Pillay & Singh 2017, p. 94). This lack of clarity affects the ability to assess maturity and mental capacity. Since these assessments are crucial in determining whether children can consent to medical treatment, ensuring they are conducted as objectively as possible is essential. The outcomes of these assessments determine whether a child is judged to have sufficient maturity to provide consent.

In this study, I aim to fill in this gap by arguing that the application of Section 129(2) in its current state can potentially violate children's right to autonomy due to a lack of clear guidelines on how maturity and mental capacity ought to be assessed. Assessment of maturity and mental capacity is central to ensuring children can participate in medical decision-making. Given this central role, it is important that health professionals can objectively assess children's mental capacity and maturity to consent. To achieve this, clear guidelines are needed which specify how these assessments should be conducted and by whom. Should the treating health professional be responsible for these assessments, or should a specific category of health professionals be tasked with this responsibility? Lastly, there needs to be a common understanding of which assessment tools are suitable to ensure fairness and justice for the children being assessed.

1.3. Research Question.

Does the absence of clear guidelines on assessing maturity and mental capacity infringe on children's right to autonomy in medical treatment as provided for in Section 129(2)?

1.4. Thesis Statement.

I argue that in the absence of clear guidelines on how maturity and mental capacity ought to be assessed, children are unfairly disadvantaged by using subjective assessment measures, which infringe on their right to autonomy in medical treatment.

1.5. Objectives of the study.

This study seeks to achieve the following objectives:

- To argue that while most health professionals work with children, not all are equally equipped to conduct maturity and mental capacity assessments.
- To make a case that lack of uniform or standardised assessment measures in children leads to the use of intuitive non-standardised assessments.
- To argue that Section 129(2) in its current form is ambiguous and can potentially violate children's right to autonomy.
- To make a case that Section 129(2) in its present state is not ethically justified when examined from the perspectives of Kant's Deontology and Utilitarianism.
- To conclude that given the harm to children's autonomy, caused by Section 129(2) in its current form, there is an ethical need to amend it.

1.6. Research Design

This study will follow a normative bioethics research design. Normative ethics is the "branch of philosophical inquiry which seeks to answer questions relating to what ought to be done and what ought not to be done" (Sugarman & Sulmasy 2010, p. 2). This study will be a type 1 study that involves defending the thesis. It will seek to answer the question regarding what ought to be done to address the ethical challenge systematically and critically. This will involve using existing literature and legislation to defend the thesis.

1.7. Research Methods

This study will employ research methods and standards applicable to philosophical research. This involves conducting library-based research without collecting any new empirical evidence. Defending the thesis outlined in section 1.6 above is central to this study. This will be done by interpreting the existing legislation, such as the CA, National Health Act, Constitution of South Africa, and other legislation as applicable to the study. A critical analysis of literature relating to assessing children's mental capacity and maturity will also be conducted to defend the thesis.

1.8. Research Outcomes

This study is part of the Master of Science degree in Medicine, and successful completion will lead to the award of the degree. Secondly, the study results will be presented at conferences like the Psychological Society of South Africa (PSYSSA). Thirdly, the study will be published in medical ethics journals.

1.9. Ethical Clearance

The research is purely normative, and ethical clearance was not required since no empirical data will be collected. The research protocol was submitted to the University of Witwatersrand higher degree committee and received approval.

1.10. Limitations

The major limitation of this study is the lack of empirical evidence relating to assessing children's mental capacity and maturity in South Africa. There is also no empirical data regarding current practices in obtaining informed consent in children. Only one study specifically focused on the current practices in obtaining informed consent from children in South Africa could be found.

CHAPTER 2

Competencies of health professionals in assessing children's maturity and mental capacity.

2.1 Introduction

In this chapter, I focus on health professionals' competencies in assessing children's maturity and mental capacity. I argue that although Section 129(2) requires an assessment of children's maturity and mental capacity, not all health professionals are competent to conduct such assessments. To support my argument, I highlight the complexities of assessing the children's maturity and mental capacity. I then explain what the term "health professionals" means as defined in the Health Professions Act 56 of 1974 (hereinafter referred to as HPA). The HPA stipulates that anybody registered under that act is referred to as a health professional. This creates a challenge regarding Section 129(2) as it does not specify which category of health professionals should conduct maturity and mental capacity assessments. For this report, health professionals will refer to medical doctors as the health professionals responsible for providing medical treatment and psychologists as health professionals who specialise in cognitive and mental capacity assessments.

To further support my argument, I will examine the relationship between the definition of health professionals and the scope of practice for general practitioners and psychologists. Discussing the scope of practice will highlight which professionals should be responsible for conducting assessments of maturity and mental capacity. This discussion will shed

light on the limits of a health professional's knowledge, skills, and experience. It will also show all tasks and activities they are expected to carry out professionally. The analysis of the scope of practice will be focused solely on these two categories of health professionals, as they are considered the only relevant ones within the scope of Section 129(2). I will conclude by emphasising how psychologists, as mental health professionals, are best qualified to perform maturity and mental capacity assessments compared to medical doctors.

2.2 The complexities of maturity and mental capacity assessments.

Assessment of children's mental capacity is an essential concept in medicine as it relates to children's competency to participate in medical decision-making. Hein et al. (2015, p.1) define competency as the person's ability to consent to medical interventions, which is generally addressed as decision-making capacity. Throughout history, children have been considered immature and incompetent to provide valid legal consent (Daly 2020, p. 492). Because of this immaturity, parents have always been considered the best surrogate decision-makers. Limiting children's decision-making has always been to protect them from their immaturity (Kruger 2018, p. 2), as medical decisions can have long-lasting implications on their future development.

The ratification of the UNCRC, which acknowledges children's capacity to engage in medical decisions, has fundamentally changed how decisions have historically been made regarding children. It changed decision-making focus from parents acting alone to recognising children's capacity for input into medical decisions. Considering that not all

children can make such decisions, assessing their capacity to provide informed consent for medical treatment becomes crucial. The CA specifies two legal requirements that must be met for the child to provide consent: they must be 12 years of age and have “sufficient maturity to understand the benefits and implications of the proposed treatment”. Therefore, mental capacity and maturity assessment fulfils the second legal requirement and provides evidence that a 12-year-old is competent to provide consent (Kruger 2018, p. 3). Therefore, obtaining an impartial and precise evaluation of a child's maturity and mental capacity is imperative to enable them to make well-informed medical decisions due to the implications of such consent. It is Herring’s (2016, p. 55) view that the rationale for ensuring an objective and accurate assessment of children's mental capacity is twofold:

> First, you could be assessed to lack capacity when you do not … You lose control over your life and ability to make decisions. Second, you could be considered to have capacity when you do not have it; you could suffer harm and injuries, and you would be told that it was your choice.

Herring (2016, p. 55) highlights the significant impact of assessing children’s maturity and mental capacity on medical decision-making. Although the requirement to assess children's ability to consent has drawn more attention in the last decade, there is no consensus on how to go about it. Hein et al. (2015, p. 4) call the situation a "hodgepodge of practices”. This is because there is a lack of clear standards on how to conduct these assessments, and there is also no empirical evidence to support any conclusions taken. Pillay & Singh (2017, p. 3) believe this situation is further complicated by the lack of standardised assessments, leading health professionals to use intuitive non-standardised assessments.

The absence of clear assessment guidelines furthermore raises issues of justice and fairness towards children, as each professional uses their judgment to conclude whether the child is mature enough to consent. It is Daly's (2020, p. 475) view that in the absence of objective and standardised tools to assess children's capacity to consent, the idea that children can make informed decisions may simply reflect the biases of the medical professionals. Daly (2020, p. 475) believes that health professionals may justify decisions regarding children's capacity to consent without empirical data, leading to biased and unfair assessments.

Four main challenges underlie maturity and mental capacity assessments. The first challenge concerns defining maturity and mental capacity (Pillay & Singh (2017, p. 4). Before discussing objective assessments, we must define the concept and ensure a shared understanding. This is because once there is a common understanding of what the concept entails, standard assessment measures can be used, increasing the validity and reliability of such assessments. However, without a standard definition of the concept, the decision is left to individual practitioners to use their own experiences and views to make decisions regarding children's ability to consent (Pillay & Singh (2017, p. 4).

The lack of a standard definition becomes even more challenging if the same concept must be applied across different medical fields, such as psychology, medicine, and law. For example, Daly (2020, p. 473) defines capacity "as one's cognitive abilities, i.e., mental processes such as knowing, judging, and evaluating". Within psychology, there is a widely

accepted understanding of the cognitive abilities typically exhibited by 12-year-olds and how to evaluate them (van Heerden, Delport & Kruger 2020, p. 25). While various assessment methods may be utilised, there is a shared comprehension of the overall concept. When it comes to consent to medical treatment, applying the same definition becomes a complex task for general practitioners to fully understand the cognitive functioning of 12-year-olds and how to assess it because of the different areas of expertise.

The second challenge relates to understanding human development across the lifespan and its impact on children's maturity and mental capacity. Human development plays a significant role as it helps us understand what is expected at different stages of development and tailor-make interventions that suit individuals' level of development (Hein et al. 2017, p. 3). Generally, human development takes place in three main areas, cognitive, physical, and psychosocial (Berk 2007, p. 24). Theorists have different views of what influences maturity and how it affects decision-making, and I will explore two of them, namely, Piaget and Erickson. Piaget focused solely on human development from the perspective of the cognitive ability of children as they develop from concrete thinking to abstract thinking (Berk 2007, p. 24). Erickson’s psycho-social development theory, on the other hand, focuses on human development from the psychosocial perspective on how social interaction can have a significant impact on children's maturity and decision-making capacity (Berk 2007, p. 25).

When assessing the maturity of children, it is important to consider the theories that provide insight into the complex decision-making process of children. Erickson highlights that this stage of development which he terms adolescence, is dominated by significant neurological changes that greatly influence decision-making competency (Berk 2007, p. 25). This viewpoint is reinforced by Piaget's theory that children transition from concrete to logical and abstract thinking around the age of 12 years (Berk 2007, p. 25). The most significant changes in the brain that 12-year-olds go through are “associated with processing rewards and risks, self-regulation, and the effect of peers on decision-making” (Hein et al. 2015, p. 5), which affects decision-making in general. When assessing children's decision-making capacity, it is therefore imperative to consider their developmental stage, typical behaviour, and relevant factors that may impact assessment outcomes.

The third challenge is that assessment of children’s mental capacity to consent is a legal requirement, as highlighted in the CA. However, it is unclear how the law interprets maturity and mental capacity, as the South African legal system provides little guidance. There is a lack of legal precedent on how the South African courts will handle this matter should the dispute arise on whether the children can provide consent. However, Section 39 of the Constitution allows for using international and foreign law in these circumstances. Although the foreign law might not be binding, it may shed some light on how the case might be interpreted.

One significant case to consider is the British case of *Gillick v West Norfolk and Wisbech Area Health Authority (1985)*. In this case, the question was whether a medical practitioner could prescribe contraceptives to a patient under 16 without parental consent. Mrs. Gillick, a mother of 5 girls under the age of 16, requested that the Court declare the Department of Health's circular, which permitted health practitioners to give contraceptives to individuals under 16 without parental consent, as illegal. Mrs Gillick argued in her application that allowing children below 16 to receive treatment on contraceptives will contravene parental rights. However, the majority of the House of Lords rejected her claim after determining that there were circumstances in which a child could consent to their medical treatment. To do so, “the child must have a sufficient understanding and intelligence to enable him or her to fully understand the benefits and consequences of the proposed treatment or medical intervention”.

The ruling in the Gillick case is commonly referred to as the Gillick competence or the mature minor doctrine. It is used in England and Wales when dealing with cases concerning children's ability to consent to medical treatment. However, even in these countries where Gillick competency is used, the courts have given little guidance on how the practitioners should define and assess this concept (Daly 2020, p. 476). However, the court in the *Gillick case* did recognise that for a child to have the legal capacity to consent to medical treatment, there are many factors to consider beyond just medical advice. These factors include moral reasoning, the potential long-term emotional consequences of the decision, and the child's relationship with their parents (Bird 2011, p.1). One can, therefore, conclude that determining the mental capacity of children is not straightforward.

It is Herring's (2016, p. 46) view that perhaps the complexity of this matter is why courts have refrained from providing universal guidelines on the subject and have left it up to the professionals. This is because, although it is the legislative role to create laws, the courts play a significant role in implementing and interpreting laws, ensuring the protection of the rights of ordinary citizens (Majuta, Tsoeu & Kgalema 2015, p. 21).

The last challenge relates to the nature of capacity and competency. Buchanan & Brock (1990, p.19) believe that “competence is decision-specific and context-based”. This is because a person may be competent in one situation but incompetent in another or in the same situation under different circumstances. An individual’s capacity for decision-making is influenced by a variety of factors, including “the complexity of the information shared, the individual's cognitive ability to understand the information, the environment in which the decision-making is taking place, and the behaviour of others” (Buchanan & Brock 1990, p. 19).

2.3 Defining Health Practitioner.

The HPA defines a health practitioner as any person (including a student) registered with the Health Professions Council of South Africa (hereinafter referred to as HPCSA) in one or more of the categories of health professions. From the HPA definition, everybody registered under the Council is considered a health professional regardless of their registration category, i.e., medical practitioner or psychologist. However, although everybody registered under the HPA can be regarded as a health professional, their

professional competencies differ depending on the professional board they are registered under and the scope of practice linked to that profession.

In the CA, it is unclear which health professionals the Act refers to for assessing children's maturity and mental capacity. Does being registered as a health professional under the HPA mean one is qualified to conduct maturity and mental capacity assessments? I don't believe this will be the case, considering the varying competencies and training provided to different health professionals and their differing scopes of practice. To determine the health professionals referred to in the Act, the starting point might be identifying health professionals responsible for medical treatment since Section 129(2) is specific to consent for medical treatment. van der Westhuizen (2018, p. 793) defines medical treatment as any procedure for diagnosing or treating any physical illness or defect. Section 36(1) of the HPA describes the scope of practice of medical doctors as diagnosing and treating physical illness. Based on the above definition of medical treatment and the professionals who provide it, it can be concluded that the health professionals mentioned in Section 129(2) are medical doctors.

Section 34(1) and (2) of the HPA states that each professional board has its scope of practice unique to the professionals registered under that board. It is a criminal offence for any other person to practice under that profession if they are not registered. Currently, HPCSA has 12 professional boards, each consisting of a different profession, such as the board for psychology. It is Mulder's (2014, p. 109) view that specific training and education offered to individuals in each health profession distinguishes them from other health

professionals. For example, the different training received distinguishes medical practitioners from psychologists. It furthermore assists in differentiating between different specialties in the same field. For example, distinguish between psychiatrists and neurologists in the medical field or clinical and educational psychologists within the psychology field.

In the context of the definition by the HPA, it is vital to consider the intention behind using the term "health professional" in the CA without specific reference to a particular health profession. It would have been clearer if the CA referred specifically to medical doctors instead of using the term "health professionals." Once it is established that medical doctors are responsible for medical treatment, the question remains whether they are competent to conduct maturity and mental capacity assessments. This raises ethical challenges for medical practitioners, as maturity and mental capacity are related to individuals' cognitive functioning, which falls within the competencies of psychologists.
However, the CA does not explicitly state that psychologists should assess whether children have sufficient maturity and mental capacity to consent or that the decision to determine children's maturity. Therefore, there remains a lack of clarity regarding who should be responsible for assessing children's maturity and mental capacity, as this is not clarified in the CA.

2.4 Health professionals and scope of practice

The professional scope of practice is based on the profession's knowledge, education, evidence, and practice frameworks (Mulder 2014, p. 110). The HPCSA defines the scope

of practice in terms of ethical rule 21, which states that: “A practitioner shall perform, except in an emergency, only a professional act - (a) for which he or she is adequately educated, trained and sufficiently experienced; and (b) under proper conditions and in appropriate surroundings.” Central to the scope of practice is the training and experience one has received to carry out assigned professional activities. Because healthcare is such a vast field, it is challenging for healthcare professionals to manage all health-related activities. To address this, the scope of practice defines specific areas where professionals can work and develop their skills. This helps ensure that every professional is competent within their area of expertise.

Expanding the scope of practice is a contentious topic in the medical community, particularly when one profession seeks to broaden its current practices. There have been conflicts regarding what other health professionals can and cannot do based on their training and the body of knowledge acquired. In 2021, medical doctors did not take kindly to the published gazette by the Pharmacy Council, where suggestions were made for pharmacists to manage patients for antiretroviral medication, pre-exposure prophylaxis, and post-exposure prophylaxis. The argument put forward by the pharmacy council in support of this extended scope of practice was to expand public access to health services as pharmacists are more widely available and cheaper to access. However, the South African Medical Association (SAMA) described this move as an ‘unlawful and unfair’ competition created between pharmacists and medical doctors (Medical Brief, 2021). This move is unlawful in the HPA Section 34 (1) and (2), which stipulates that it is a criminal offense to practice out of their scope of practice.

SAMA argues that it becomes an unfair competition for pharmacists to compete in the field of diagnoses and treatment while they have different training, experience, and expertise. Within the same context, one can argue that if medical doctors are then expected to conduct maturity and mental capacity assessments, which fall within the scope of practice of psychologists, it will violate Rule 21. Psychologists could argue that this move is unfair and unlawful, as they would be expected to compete with medical doctors despite having entirely different training and experience. Additionally, this change could put children at a disadvantage, as medical doctors are not trained to conduct mental capacity assessments, which are not within their scope of practice. Therefore, it would be unlawful for them to provide services for which they are not trained and competent. This move should prioritise protecting and promoting “the best interests of the children”. As highlighted by Dr. Camp-Rogers from the American Medical Association (AMA), “Scope of practice is important because of the impact that practicing outside of your scope has on public health and safety” (Berg 2022, p.1). Central to the scope of practice conflicts is competency and training received in carrying out tasks traditionally performed by other professionals, such as medical doctors.

The challenge with the scope of practice is not limited to health professionals across different health professional boards, such as medical and dental, versus the pharmacy board. According to Fisher et al. (2016, p. 583), following the scope of practice guidelines is necessary even within the same professional board, as different registration categories have varying authorised activities. For example, the professional board of Psychology

has different registration categories, such as psychologists (educational, clinical, research, industrial), psychometrists, and registered counsellors, all with their scope of practice depending on their training and competency. For example, psychometrists in psychology are not allowed to conduct forensic or other specialised assessments, such as neuropsychological assessments (HPCSA Form 94 2019, p. 12). These assessments require highly specialised and advanced therapeutic knowledge and skills only psychologists with master's training can provide. The scope of practice, therefore, serves a significant role in healthcare as it guides practitioners on what they can do and what is beyond their competency level.

The HPCSA (2021) introduced Continuous Professional Development (hereinafter referred to as CPD) to safeguard the public and meet patient needs. With the introduction of CPD, questions arose regarding whether completing an accredited CPD short course is adequate to demonstrate competence in a new area (Medical Brief, 2021). One argument is that it depends on the duration and intensity of the course, as well as whether sufficient supervision was provided to ensure competency before working independently (Medical Brief, 2021). The HPCSA recognises the constant changes in healthcare. To ensure quality services are rendered to the public, professionals must continuously update their knowledge, skills, and abilities (HPCSA, 2021). Their fundamental view is that unless one is competent in the specific field and area, they will likely harm the public they serve (HPCSA, 2021). One must practice within one's scope of practice, and when new therapies and treatment methods are introduced, one must acquire the necessary education and experience. Having outlined the scope of practice and why it is important,

I will focus specifically on the scope of practice for medical practitioners and psychologists.

a) Scope of Practice of General Practitioners

Section 36 (1) (a) to (c) of the HPA describes the following acts as falling under the scope of practice of medical practitioners, generally referred to as general practitioners:

> *"(i) physically examines any person; (ii) performs any action of diagnosing, treating, or preventing any physical defect, illness, or deficiency in respect of any person. (iii) advises any person on his physical state; (iv) on the ground of information provided by any person or obtained from him in any manner whatsoever- (aa) diagnoses such person's physical state; (bb) advises such a person on his physical state; (cc) supplies or sells to or prescribes for such person any medicine or treatment*".

The focus of general practitioners is to perform physical examinations, diagnose physical defects, and provide necessary treatment. This creates a challenge regarding competency in conducting maturity and mental capacity assessments. There is no clear indication of how medical practitioners should conduct maturity and mental capacity assessments if their scope of practice is limited to diagnosing and treating physical defects. Pillay & Singh (2017, p. 5) argue that medical doctors often only consider a child's physical development when assessing maturity. However, child development encompasses both physical and mental growth. This is because valid consent depends on a child's cognitive maturity to understand the risks and consequences of a proposed treatment, as highlighted in Section 129(2). While physical development involves evaluating a child's growth and physical changes, focusing solely on this aspect neglects

the crucial evaluation of the child's mental capacity to comprehend the proposed treatment's risks, benefits, and consequences (Pillay & Singh 2017, p. 5).

b) Scope of Practice of Psychologists.

According to the HPA, Section 37(2)(a) to (h), the following acts are deemed to be specifically about the profession of a psychologist:

> *"(a) The evaluation of behaviour or mental processes… through the interpretation of tests for the determination of intellectual abilities…and the diagnosis of personality and emotional functions and cognitive functioning deficiencies according to a recognised scientific system for the classification of mental defects. (c) The evaluation of emotional, behavioural, and cognitive processes or adjustment of the personality of individuals or groups of persons by the usage and interpretation of questionnaires, tests… for the determination of intellectual abilities... (d) The development of and control over the development of questionnaires, tests... instruments for the determination of intellectual abilities… psychophysiological functioning, or psychopathology".*

The scope of practice of psychologists focuses mainly on the mental functioning of the individuals, including cognitive, personality, behavioural, and adjustment challenges that individuals might experience. Furthermore, the HPA Section 37(2)(d) puts the responsibility on the psychologist to develop and control the use of any assessment measures and tools to assess the mental, cognitive, and behavioural functioning of the individuals. It makes more sense for psychologists to assess children's maturity and mental capacity, aligning with their practice scope. I argue that it is unlawful under the HPA to assign other healthcare professionals to perform psychological acts without the

required competence and training. In this context, competence involves more than just intuitive assessments (Fisher et al., 2016, p. 584); it also requires proficiency in choosing suitable tests, administering tests, and interpreting results.

2.5 Competencies of the health professionals.

Competency is central to healthcare as it forms the basis of providing quality services to patients and the community. Mulder (2014, p. 108) summarises the concept of competency in healthcare as “the ability of healthcare professionals to serve effectively both the individual and the wider community according to the rules of clinical performance”. Competency provides us with a shared understanding of the behaviour expected from individuals in health professions. Competence relates to a professional's scope of practice (Mulder 2014, p. 108), as one can serve effectively if trained in the field and operates within the rules of clinical practice.

Considering the complex terrain of mental capacity assessments, competency is central to promoting children’s rights to self-determination. The central idea of children’s right to self-determination is ensuring their best interests are protected and promoted (Kruger 2018, p. 14). If the health professional’s competencies in assessing children’s mental capacity and maturity have not been established, are children’s interests protected? This remains a challenging question regarding Section 129(2) because it does not provide any direction regarding the competency of medical practitioners to carry out this task. One can argue that crucial factors are, therefore, the opinions and judgments of the medical specialists regarding whether a certain child is mentally capable.

The HPA Section 36(1)(a) describes the scope of practice for general practitioners as focusing primarily on physically examining patients to diagnose and treat physical ailments. According to Pillay and Willows (2015, p. 98), general practitioners tend to focus on the physical development of children when assessing their maturity, which is in line with their scope of practice and competencies. However, this approach overlooks the critical aspect of maturity related to the cognitive ability to understand the potential risks, benefits, and consequences of suggested treatments. If general practitioners were to conduct cognitive assessments, they might exceed their scope of practice, raising concerns about the accuracy and consistency of such assessments. In this context, Daly (2020, p. 495) argues that professionals working with children and dealing with the capacity to consent to medical treatment have relied mainly on their experience and intuition to recognise capacity, with little knowledge of relevant research or theory.

When comparing the scope of practice of psychologists, one can say that they are the best trained and qualified to conduct maturity and mental capacity assessments as opposed to medical practitioners. This is because the assessment of individual intellectual functioning falls within the scope of psychologists, and so is the control of any assessment’s measures relating to cognitive functioning. Maturity and mental capacity require the assessment of an individual's cognitive ability to understand the information given and to make the decision whether to consent to the treatment or not. However, this position is currently not provided for in the CA.

The current legal position burdens medical practitioners to assess the maturity and mental capacity of children being treated. However, it does not indicate that medical practitioners should collaborate with psychologists during this process. If medical practitioners are responsible for determining children's maturity and mental capacity, it could lead to ethical challenges related to beneficence and non-maleficence. This is because practitioners are not trained to conduct these assessments, which may not be in the children's best interests. To avoid harm and potential violation of children's autonomy rights, practitioners should only perform acts within their scope of practice.

2.6. Different categories of psychologists

To further emphasise the argument regarding which health professionals should conduct assessments of maturity and mental capacity, it is essential to note that not all professionals within the field of psychology are fully equipped to evaluate children's maturity and mental capacity. The psychology board has various registration categories: educational, clinical, counseling, industrial, research, neuropsychology, registered counselors, and psychometrists (HPCSA, 2011). Among these categories, clinical, counseling, and educational psychologists are best suited to assess children's maturity and intellectual capacity.

A counselling psychologist’s primary function is to assess and intervene with individuals dealing with life and developmental challenges and adjustment (HPCSA, 2011). Assessing maturity and mental capacity could fall within the broad range of developmental and adjustment challenges that counselling psychologists often address.

However, since the assessment is related to children's ability to understand the risks and benefits associated with medical treatment, one could also argue that clinical psychologists working within hospital settings could be best placed to assess children's maturity. This could create the best scenario for being part of the multidisciplinary team involving the treating practitioner in ensuring that the children receive sufficient treatment information, which could be incorporated into the assessments. Given the shortages of clinical psychologists in hospital settings, the alternative scenario, where there is an educational psychologist linked to the school since most 12-year-olds are likely to be in school, an educational psychologist could also assist in working in collaboration with the treating practitioner to assess children's maturity and mental capacity.

There is a need for a standardised method to assess maturity and mental capacity, as different psychologists can provide valuable insights into children's functioning and their capacity to consent. Ultimately, a team approach could improve the quality of assessments and ensure that everybody sticks to their scope of practice, thereby promoting children's best interests. Educational psychologists can offer perspectives on learning and development, while counseling psychologists can contribute insights on developmental adjustment (HPCSA, 2011). Additionally, clinical psychologists can provide valuable information regarding any psychopathology, such as depression or anxiety, that children may be experiencing (HPCSA, 2011).

Research psychologists and psychometrists have a significant role in this context, mainly because no specific tests have been developed for this purpose. For the development of

these tests, the expertise of psychometrists and research psychologists will be crucial, as psychometrists primarily focus on developing and performing psychological assessments (HPCSA, 2011). Meanwhile, research psychologists are tasked with investigating the psychological processes involved in assessment development and overseeing the monitoring and evaluation of assessments and interventions (HPCSA, 2011). Intensive research is necessary to identify the best methods for assessing children's maturity and mental capacity. Once assessment tools are developed, ongoing monitoring and evaluation will ensure that these assessments meet the required standards and possess solid psychometric properties. This process will involve the expertise of both research psychologists and psychometrists.

2.7 Challenges with mental health services in South Africa

In summary, my proposal suggesting that mental health specialists should evaluate children's mental capacity may raise concerns. In some regions of South Africa, such as Mpumalanga, Limpopo, and Eastern Cape, there is a significant shortage of psychologists in the public sector, with vacancy rates ranging from 80-85% (Teichmann, 2022, p. 1). This shortage could make it challenging to implement the proposed approach due to budget constraints and a scarcity of mental health professionals available to serve the public sector. As a result, involving mental health practitioners in assessing the maturity and mental capacity of children may not be practical.

This raises an ethical challenge for healthcare professionals. Firstly, would compromising the quality of care and allowing healthcare professionals to exceed their scope of practice

be acceptable due to limited resources and staffing? Suppose practitioners are allowed to provide services for which they are not qualified or trained. In that case, revising the HPA to remove criminal liability for practising outside one's scope may be necessary. This is crucial because being reported to the HPCSA has a detrimental impact on health professionals and ultimately affects their ability to fulfil their duties (Govender, 2023).

Health professionals have a moral obligation to promote and protect children's rights. Therefore, it is necessary to carefully balance the risks and benefits of the decisions we make in healthcare. In this case, the risks far outweigh the benefits of compromising the quality of services provided to children due to budget constraints. What implications does this have on the quality of health care services rendered to children if the practitioners are not competent and qualified to provide the service? Considering these are high-stakes assessments that have profound implications on children's participation in medical decision-making, can we use budgetary constraints and human resource challenges as excuses for health professionals, or do we need to prioritise the best interests of children?

It is also essential to consider this against the current rise in medical malpractice litigation and health professionals being continuously reported to the HPCSA for unethical conduct and acting beyond their scope of practice. At the heart of this medical malpractice litigation is the quality of care received by patients, especially in the public sector, where health professionals are expected to deliver quality services under challenging conditions (Prinsen, 2023, p. 1141). The impact of understaffed health facilities and the lack of

specialists in some facilities has already been felt in terms of poor services and increased litigation.

According to Nguse & Wassenaar (2021, p. 306), a significant challenge in South Africa is the lack of implementation of legislation, creating a gap between policy development and implementation. This issue is also observed in other legislative and policy frameworks, such as the Mental Health Care Act of 2002 and the National Mental Health Policy Framework and Strategic Plan 2013–2020, which face obstacles to effectively implement (Nguse & Wassenaar 2021, p. 306). Additionally, a study by Havenga & Temane (2016, p. 645) highlighted that health professionals in South Africa have limited knowledge of Section 129(2) concerning obtaining consent from children. The study noted that many health professionals either do not provide treatment to children without their parents present or offer treatment without assessing the child's mental capacity to consent (Havenga & Temane 2016, p. 646). Havenga & Temane (2016, p. 646) further highlight that even those who know the importance of assessing children's maturity and mental capacity to consent are ill-prepared.

In its current form, the CA may infringe on children's autonomy rights due to the lack of implementation guidelines. Without guidelines, budget, and human resources, challenges in the mental health sector cannot be addressed effectively. Increasing the budget allocation to the mental health sector is essential, as only 5% of the national budget is currently spent on mental health (Nguse & Wassenaar 2021, p. 306). The current implementation of Section 129(2) of the CA is at risk of not achieving its intended purpose

due to a lack of proper guidelines and budget allocations. The CA aims to ensure that children are involved in decision-making, taking into consideration their age and stage of development as outlined in Section 10 of the CA. However, there is a need for clarity on how this should be effectively implemented in healthcare. Without clear guidelines, I argue that the CA will likely fail to promote children's right to participate in medical decision-making. In such circumstances, it should be revised, as an unenforceable act serves no purpose in medicine and law.

CHAPTER 3

The use of standardised instruments in assessing children's maturity and mental capacity to consent to medical treatment.

3.1 Introduction

Central to Section 129(2) is the need for health professionals to assess children's maturity and mental capacity to consent to treatment. Even though the CA has been in effect for over a decade, it is still unclear what assessment measures are utilised to assess the children's mental capacity. No standardised assessments have been developed specifically for this task in South Africa. In this chapter, I highlight that there are currently no standardised assessments to determine children's mental capacity and maturity, and I, therefore, argue that this is not in the best interest of the child as it leads to the use of intuitive assessments.

To support my argument, I will begin by defining a psychological construct and explaining why it is important to consider the assessment of children's maturity and mental capacity as a psychological act or assessment. Psychological assessment refers to any form of evaluation that analyses a person's mental, emotional, and intellectual functioning and capabilities (Cohen & Swerdlik 2005, p. 35). Mental capacity and maturity assessment can be considered a psychological assessment of the individual's mental and intellectual functioning. Before discussing assessing maturity and mental capacity, it is crucial to clarify what these constructs mean for three reasons. Firstly, the CA does not provide any definition of these constructs. Secondly, it does not specify which health professionals are

best suited for these assessments. Finally, there are no guidelines on how to conduct these assessments or which assessment measures to use.

I will then discuss the importance of using standardised assessments and how they promote the best interests of children. Furthermore, I will explore the use of intuitive assessment as a current practice in South Africa to evaluate children's maturity and mental capacity. I will also highlight the unethical nature of these assessments. I will conclude that due to a lack of standardised assessments for evaluating children's maturity and mental capacity, health professionals rely on intuitive assessments, which might not be valid and reliable.

3. 2 Understanding psychological assessment and testing.

Understanding the definitions of psychological acts and constructs is crucial to grasp how psychological assessment relates to a child's ability to consent to medical treatment. Psychological constructs, such as theories and hypotheses, are scientific tools that help understand human behaviour (Price et al. 2017, p. 70). They are hypothetical mental constructions deduced from observable behaviours and ideas (Price et al. 2017, p. 70). For example, mental capacity cannot be directly observed, so we cannot simply look at a child and determine if they have the mental capacity to consent to medical treatment. Hence, Chima (2013, p. 4) warns that health professionals should not judge individuals' ability to provide consent based on their age, physical appearance, or any other irrelevant characteristic that could lead to unfair judgments. While these characteristics are

essential in the assessment process, they cannot be used alone to determine an individual's maturity and mental capacity.

Daly (2020, p. 405) defines mental capacity as the assessment of “individual cognitive abilities and mental processes such as knowing, judging, and evaluating”. From this definition, what is measured is observable behaviour, such as reasoning, judging, understanding, and the ability to use the information presented to make decisions. These clusters of observable behaviour (reasoning, judging, and understanding) allow the inference to be made regarding one's mental capacity. Psychological assessment, therefore, becomes a “process-oriented approach to collect data about these observable behaviours to facilitate decision-making” (Du Preez & De Klerk 2019, p. 2). From this data, inferences are made to help inform decisions and provide recommendations on the child’s ability to consent to medical treatment.

Additionally, HPA, Section 37 (2)(a)(b)(c)(d), and (e), defines a psychological act as “the use of measures to assess mental, cognitive, or behavioural processes and functioning, intellectual or cognitive ability or functioning, aptitude, interest emotions, personality, psychophysiological functioning, or psychopathology”. The HPA Section 37(2) says that psychologists have control over the development and utilisation of psychological assessment tools and materials. Assessment of children's maturity and mental capacity to consent to medical treatment can, therefore, be regarded as a psychological act as it involves the assessment of a psychological construct. Ultimately, it appears that the HPA

puts the performance of any psychological acts within the scope of practice of psychologists.

3.3 The importance of using standardised assessments.

A standardised assessment is a measure that can be consistently administered and scored using a set of predetermined standards (Price et al., 2017, p. 80). Standardised assessments are based on two main assumptions relating to objectivity and validity. The first assumption is that a standardised test can be objectively applied to the norm group without bias (Price et al., 2017, p. 80). There are many biases involved in psychological assessments, including those related to cultural differences, individuals' socioeconomic status, and language barriers (Suzuki & Ponterotto 2008, p. 189). To achieve objectivity and minimise bias, it is crucial to apply these assessments to the group they were standardised for. Applying them to a different group with diverse cultural, socio-economic statuses, and language backgrounds may result in biased results (Suzuki & Ponterotto 2008, p. 189).

In addition to cultural and language biases, the accuracy of psychological assessments can be affected by environmental factors or testing conditions (Barbie & Mouton 2007, p. 180). Criterion validity, which evaluates an individual's performance against predetermined standards, is a validity construct likely to be influenced by test conditions (Barbie & Mouton 2007, p.180). Therefore, to guard against this bias, one needs to be familiar with the test manual to establish under which conditions the test must be administered. Standardised administration procedures “usually require a quiet,

distraction-free environment, precise reading of instructions, and provision of necessary tools or stimuli" (Jacklin & Cockcroft 2013, p.169). If these conditions differ from those under which the test was standardised, the results may be biased and cannot be compared to the norm group used to develop the assessment criteria (Jacklin & Cockcroft 2013, p.169). Therefore, it is essential to consider environmental factors when administering psychological assessments to ensure the most accurate and fair results.

The second assumption underlying standardised assessments is that they aim to objectively and precisely evaluate the concept they claim to measure (Price et al. 2017, p. 87). Therefore, the standardisation process seeks to develop valid and reliable assessment tools. The validity of an assessment is the degree to which it accurately reflects the variable being assessed (Price et al. 2017, p. 89). This relates to whether the assessment instrument measures what it claims to measure and is aligned with the underlying theory and concepts (Cohen & Swerdlik 2005, p. 349). To improve the validity of an assessment tool, the construct being assessed must be operationally defined and understood within a theoretical context (Barbie & Mouton 2007, p. 190). When the tool's items are connected to its operationally defined theory and concepts, this supports its validity.

Reliability, on the other hand, refers to the consistency and accuracy of an assessment measure when used multiple times (Barbie & Mouton 2007, p. 181). For an assessment tool to be considered reliable, it should generate consistent outcomes when repeatedly administered. It is unacceptable for a child to be considered competent on one day and

for a different assessor to obtain completely different results using the same assessment on another day (Price et al. 2017, p. 89). There are different forms of reliability, such as test-retest, internal consistency, and interrater reliability (Barbie & Mouton 2007, p. 183). Among these, interrater reliability is particularly important in this study as it focuses on the consistency of different observers' judgments (Barbie & Mouton 2007, p. 183). High interrater reliability ensures that different assessors can reach the same conclusion regarding the child being assessed (Barbie & Mouton 2007, p. 183). This promotes agreement among assessors, thereby protecting the child's best interests and ensuring fair and just decisions about their welfare.

Validity and reliability in standardised assessments are important, especially in high-stakes assessments. High-stakes assessments can be described as assessments that have important consequences for the test taker (Marchant 2004, p. 2). Assessment of children's maturity and mental capacity can be regarded as a high-stakes assessment due to the impact of the assessment outcomes on the children's rights to participate in medical decision-making. In high stakes, there is always something to either lose or gain because of the assessment (Marchant 2004, p. 2); in this case, the child either gains or loses their autonomy to consent to their treatment. If the child is assessed to have mental capacity, then he/she can make autonomous decisions; should the child be considered not to have the mental capacity, then autonomy is taken away from him/her. Furthermore, these assessments have high stakes since children's consent can significantly impact their health and future well-being, especially if they lack the mental capacity to understand the consequences of the proposed treatment.

3.4 Intuitive non-standardised assessments.

In the earlier sections, I outlined the significance of utilising standardised assessments and their associated benefits. These assessments serve two primary purposes: to ensure that the tests used are valid (meaning they measure what they are meant to measure) (Price et al. 2017, p. 89) and reliable (they can be consistently applied across the population) (Price et al. 2017, p. 89). Additionally, to prevent discrimination against children based on unimportant factors like socioeconomic status, race, language, and cultural prejudices, assessments must be fair (Jacklin & Cockcroft 2013, p.169). Thus, standardised testing becomes the ideal scenario in which children's mental maturity may be objectively evaluated and provide results of their capacity to consent to medical treatment. However, this ideal situation is far from reality in the current South African context due to the lack of standardised assessments explicitly developed for this purpose.

In their 2018 study that looked at the methods used by health professionals to obtain consent from children, Bester et al. (2018, p. 642) noted the absence of standardised tests for assessing children's capacity in South Africa. In the absence of these standardised assessments, Bester et al. (2018, p. 643) argued that health professionals in South Africa use different approaches to capacity assessments, which are influenced by their perceptions, attitudes, and experiences. Similarly, Ganya et al. (2016, p. 4), in their review of existing assessments, argue that despite different competence assessment measures that have been developed, there still exists no objective assessment of children's maturity and mental capacity to consent to treatment in South Africa. Ganya et al. (2016, p. 4) believe that without objective, standardised assessments

to assess children's capacity to consent, health professionals rely on subjective, intuitive assessments to fulfil this task. The findings of these two studies are like the views expressed by Hein et al. (2015, p. 156) that “health professionals can make only intuitive assessments of children’s competence because no standardised method is available to test it more objectively”.

The use of subjective, intuitive assessments raises concerns about their validity and reliability. The main question is whether they objectively assess children's mental capacity or merely reflect the assessor's views, as Hein et al. (2015, p. 4) argued. Daly (2020, p. 475) seems to support this view when he further argues that in the absence of any objective means to assess children's capacity; any assessment is about enabling professional discretion to provide treatment to children without parents' permission, rather than offering a clear means for assessing children’s capacity. At this point, weighing the benefits and costs of using subjective assessments against more standardised assessments may be necessary. The challenge is balancing the need to promote children's developing autonomy against the need to protect them from potential harm by upholding the principle of the best interests of the child.

Another obstacle stemming from subjective, intuitive evaluations is a shared agreement concerning the assessed constructs and the methods employed to measure them. This lack of consensus extends to the professional community's understanding of what maturity encompasses and how it should be gauged (Pillay & Willows 2015, p. 98). Such ambiguity around the meaning of maturity and mental capacity can lead to disagreements

among experts, as there is no standardised approach to maturity and mental capacity assessments (Daly 2020, p. 478). Furthermore, it creates confusion for the public, where a child may be deemed mature by one practitioner and immature by another, potentially compromising the reliability of any assessments.

Daly (2020, p. 479) argues that in some circumstances, an intuitive assessment of a child's capacity may be crucial owing to challenges in defining maturity. This point of view aligns with du Preez's (2011, p. 28) claim that in this complex situation, it is possible to argue that each case should be evaluated individually for maturity. Theoretically, using professional judgment and considering each child's sociocultural surroundings might help resolve this paradox of standardised assessment versus intuitive assessments. Ultimately, the argument might be that, as professionals, we can use our expertise to decide whether a child can consent.

However, du Preez (2011, p. 29) warns that this might still be difficult without clear criteria to base maturity decisions on. Since a solid definition has not yet been established satisfactorily, professionals would still benefit from a framework or guideline for assessing children’s maturity (Daly 2020, p. 479). This view is supported by Buchanan and Brock's (1990, p. 20) argument that a guiding framework and parameters are necessary for assessing individuals' capacity to consent. It cannot just be a “hedge podge” of activities, as Hein et al. (2015, p.4) put it, where everybody uses their intuitive judgment to decide on children’s capacity with no guidance or consensus on what can be done and what cannot be done.

Daly (2020, p. 495) believes that evaluating children's capacity to consent should be viewed from a "children's rights perspective". This implies that at the centre of all the assessments, the goal should be to promote children's right to autonomy and ensure their best interests are always protected (Daly 2020, p. 495). Although the CA and the Constitution are already in place, intending to promote children's rights, they only outline the county's default legal position, and the practical implementation is much more complex (Kilkelly & Liefaard 2019, p. 522). Kilkelly & Liefaard (2019, p. 522) have pointed out that while the inclusion of children's rights in the Constitution and related legislation such as the CA is a positive step, it is only the beginning of a "dynamic and intricate process that requires further actions to ensure genuine reform". Therefore, clear guidelines for health professionals can prevent ethical challenges that harm children's interests, protecting their rights beyond mere inclusion in laws and legislation.

3.5 Ethical challenges in using Intuitive non-standardised assessments.

a) Fairness in Assessment

Ensuring fairness in psychological assessments is a crucial ethical issue. It involves considering individual characteristics and testing contexts to interpret scores accurately (Marchant 2004, p. 2). Fairness goes beyond just examining the psychometric features of the test; it also considers the socioeconomic characteristics of the person being assessed (Marchant 2004, p. 2). The impact of the socioeconomic characteristics of the individuals being assessed becomes more important in a multicultural society like South Africa (Laher et al. 2022, p. 36). The country's unequal distribution of resources,

differences in the education system between private and public schools, and the difference between rural and urban education (UNICEF, 2011) all significantly contribute to how the child is likely to perform in maturity and mental capacity assessments. In standardised assessments, the norms are selected carefully to ensure that test takers are not being discriminated against by any irrelevant characteristics (Marchant 2004, p. 2). However, intuitive assessments have no guidelines on how measures are taken to ensure that contextual factors do not influence the outcomes of the assessments and ensure fairness.

The use of psychological tests in South Africa has a unique history and position (Laher et al. 2022, p. 36). This is the result of the history of the use of psychological assessments. In the past, they were used to discriminate against other groups of people, especially for employment purposes (Laher et al. 2022, p. 36). Section 8 of the Employment Equity Act 55 of 1998 was developed to ensure fairness in using psychological tests. It is important to note that although the Employment Equity Act deals specifically with employment matters, Section 8 significantly contributes to the current debate on the use of psychological assessment in assessing children's maturity and mental capacity. Its significance is that it places explicitly the responsibility on the psychologists to ensure that the assessments used are valid and reliable and do not unfairly discriminate against any child. On this note, Laher et al. (2022, p. 37) highlight that to achieve fairness, all psychological assessments should adhere to section 8 of the Employment Equity Act, whether they are used for employment purposes or not.

There are various ways in which the test can be considered fair and non-discriminatory. It should have a consistent meaning for all test takers in the intended population, reflecting the same construct Aschieri (2012, p. 351). In the context of children's competency to consent to medical treatment, this will likely prove challenging to achieve. A decade after the promulgation of the CA, there is still no consensus regarding what is meant by sufficient maturity (Pillay & Singh 2018, p. 539). This is mainly because the CA itself provides little guidance on this matter. It has left it open and subject to different interpretations, thereby being vulnerable to individual biases and attitudes. Everyone will interpret it according to their own experience, attitudes, and beliefs, likely creating bias in assessment, as highlighted in the study by Bester et al. (2018, p.641). Therefore, the main challenge becomes standardising the assessment procedures and ensuring a shared understanding of what maturity entails and how it should be assessed.

Psychological tests must be fair and not provide any advantage or disadvantage based on irrelevant characteristics such as “race, ethnicity, gender, age, socioeconomic status, linguistic or cultural background” (SIOPSA 2005). However, when assessing children's maturity and mental capacity, these factors are crucial to consider in a broader context due to their potential to influence assessment results (Buchanan & Brock 1990, p. 20). In a study about intelligence assessments for children in South Africa, van der Merwe et al. (2022, p. 7) highlight the importance of considering contextual and demographic factors to ensure the validity and reliability of intelligence instruments. Furthermore, Laher et al. (2022, p. 35) emphasise that to reduce obstacles to fair assessment, all characteristics of the intended test population must be considered throughout the assessment process,

including development, administration, scoring, interpretation, and use. By doing so, we can ensure that assessments are fair and appropriate for the intended population (Laher et al. 2022, p. 35). Although these factors should be considered, they should not be the sole basis for decision-making.

The ability of children to consent is affected by a variety of psychosocial factors, such as cognitive ability, the presence of disabilities or chronic illnesses, their personal experiences with illness and healthcare, “the seriousness and type of the health decision, and supportive parental attitudes’ (Bester et al. 2018, p. 642). These factors go beyond personal characteristics like age, race, and ethnicity. Moreover, using race and cultural background to determine an individual's mental capacity can raise ethical concerns, especially in a diverse and multicultural country like South Africa. This approach can result in cultural and linguistic biases and racial discrimination (Le Grange 2019, p.12). In 2019, Stellenbosch University published an article titled "Age- and Education-Related Effects on Cognitive Functioning in Colored South African Women." This article caused public outrage as it was seen to promote racial discrimination rooted in colonial history. According to Le Grange (2019, p.12), linking cognitive and intellectual abilities to racial categories is both unethical and discriminatory due to South African colonial and apartheid history.

The absence of standardised assessments poses a challenge for health professionals as they use different criteria to assess children's maturity and mental capacity (Bester et al. 2018, p. 649). This makes it challenging to ensure that the decision is not solely based

on consciousness, education, age, appearance, and sex. A study conducted by Chima (2013, p. 9) found that these factors are commonly used to determine whether patients can consent. Intuitive assessments can also complicate the matter since there are no established criteria, and the psychometric properties of the assessments are unknown (Pateson & Uys, 2005, p. 11). Therefore, it becomes challenging to ensure that irrelevant characteristics do not affect the outcomes of the assessments.

b) Validity and reliability of intuitive assessments

The validity and reliability of any psychological assessment are critical ethical considerations. Validity refers to the instrument's accuracy in measuring what it claims to measure (Price et al. 2017, p. 89). Intuitive assessments, which rely on subjective judgments by assessors to determine a child's ability to consent, pose challenges to the validity of the assessment. Standardisation processes use various methods to determine an instrument's validity (Price et al. 2017, p. 89), but it becomes difficult to assess the validity of intuitive assessments. This information is part of the psychometric data of the instrument, which assessors use to determine its suitability for the intended purpose (Laher et al. 2022, p. 35). However, in the case of intuitive assessments, it is unclear how assessors can be certain that the instrument is valid without access to psychometric data. In using intuitive assessment, some of the questions asked by health professionals might appear to be related to the assessment of children's maturity, but there is no scientific evidence to support if, indeed, they do so (Price et al. 2017, p. 70).

For illustration, in the study by Bester et al. (2018, p. 649), one health professional determined that the child is mature and understands the benefits and consequences of the proposed treatment for HIV because the child indicated that his mother died of HIV. This technique raises the question of whether it provides sufficient evidence that the child has understood the benefits and consequences of the treatment and is, therefore, mature and mentally capable of providing consent on their own. Considering this, I believe that while employing intuitive assessment techniques may appear legitimate, there is insufficient scientific proof to support their validity or that the children being evaluated are treated fairly.

c) Conceptualisation of maturity and mental capacity

The absence of clear criteria for assessing children's capacity is a significant challenge in psychological assessments, as without guidelines, creating unbiased and equitable assessments becomes difficult. Guidelines in this context play a vital role in improving evidence-based practice and respecting patient preferences and interests (Institute of Medicine 2011). This is done by systematically integrating the best research evidence and standardised data with clinical expertise (Danielson et al. 2019). Therefore, a good test requires a clear and complete conceptual definition of a construct, which aids practitioners' understanding of the assessed construct.

Conceptualisation is more significant in commonly used constructs like maturity, where terminology can easily be accepted without question, assuming that everyone understands the term (du Preez & de Klerk 2019, p. 2). Therefore, it is critical to

understand the intended and unintended influence of terminology and potential outcomes on assessments. Terminology allows test developers “to structure their thoughts and express predictions through language; therefore, clarifying concepts, disclosing anomalies,” questioning assumptions, and evaluating methods become essential (du Preez & de Klerk 2019, p. 3). Maturity is a complex and context-dependent concept (Buchanan & Brock 1990, p. 20). Whether an individual is considered mature depends on various socio-cultural and environmental factors that affect their growth and development (Buchanan & Brock 1990, p. 20). In this regard, the maturity assessment reflects the values and behaviours promoted in a particular culture or community (Stojkovic et al. 2022, p. 3269). Therefore, it is essential to establish a common understanding of the parameters used to assess maturity. Conceptualisation provides a valuable tool to clarify these parameters for assessors and is the first step toward developing suitable assessment measures (Barbie & Mouton 2001, p.86).

According to Moritz (2023, p. 7), “The concept of maturity is confusing, as different parties such as the law, laymen, and various professional disciplines frequently disagree on what it entails, making its assessment challenging”. This is one of the shortcomings of the CA, as it requires minors' capacity to consent to treatment to be assessed; however, it does not clearly define the terms 'mental capacity and sufficient maturity' (Pillay & Singh 2018, p. 539). The question arises as to how health professionals assess the undefined construct and how can we ensure that the assessments health professionals are conducting are the ones required by the CA? Additionally, since there is no precise conceptual explanation of maturity as a construct, we have no means to evaluate whether

the assessments are valid (Ruhe et al. 2015, p. 778). In the end, conceptualising the construct ultimately assists in creating a shared understanding and evaluation of the instrument's validity and whether they measure what they purport to measure (Moye & Marson 2007, p. 1059).

The process of conceptualisation gives meaning, purpose, and expression through clear and descriptive language (Ruhe et al. 2015, p. 778). This aligns with the literal interpretation of statutes requiring unambiguous language (Du Plessis 2002, p. 93). The interpretation of statutes provides insight into how the Act could be interpreted in the legal context. Du Plessis (2002, p. 93) states, “Legislative authority is unquestioningly deferred to, and no one dares to tamper with the very words that the legislature uses to express its will. It is assumed that statutory language should be accepted as it is if it is unambiguous and accurately reflects legislative intent (Du Plessis 2002, p. 93). The next chapter will delve into the detailed arguments and descriptions of the literal interpretation of the statute and challenges related to the lack of clarity regarding the words used.

d) Competence of Assessors

The psychological tests are as good as the skills and competencies of the test user. One of the main goals of conducting psychological assessments is to ensure that test scores provide accurate interpretations for their intended purposes (PSYSSA 2007, p. 27). The validity of a test's interpretations relies heavily on the competence and proficiency of the test administrator in selecting pertinent test material and in administering and analysing the test results (Aschieri 2012, p. 351). Although there are widely available test materials

with good psychometric properties, one still needs to evaluate if it is likely to yield valid interpretations for the specific population (SIOPSA 2005, p. 25). This is because some tests might have good psychometric properties but might not be suitable for a multicultural context (SIOPSA 2005, p. 25).

The assessor's skills are crucial when it comes to the principle of beneficence and non-maleficence (PSYSSA 2007, p. 27). This is because unqualified and inexperienced practitioners can do more harm than good to the children assessed. Practitioners working with South Africans, especially children of different cultural backgrounds, must possess a "high level of cultural sensitivity and ethical awareness to conduct fair and appropriate psychological assessments" (van der Merwe et al. 2020, p. 2). They should also be conscious of societal inequalities' impact on assessment outcomes (van der Merwe et al. 2020, p. 2). Competency also includes selecting psychologically sound assessment material that is valid and reliable for the intended purpose. Assessments that rely on intuition rather than sound psychometrics can also harm children for two reasons: one is that it is unclear which construct is being measured, and second, what instructions are being provided to create a conducive environment for test takers. Furthermore, intuitive assessments raise the question of what competencies assessors require to ensure fairness and objectivity.

3.6 The use of psychological assessments in South Africa

Regardless of the advantages of standardised psychological tests in assessing children's maturity and mental capacity, one can still argue that it does not come without their

shortcomings. One of the strongest objections regarding the use of psychological tests in South Africa stems from the troubled past of their usage (Laher & Cockcroft 2013, p. 3). Psychological assessment is arguably unfair to specific groups of people in South Africa due to the political, socioeconomic, and educational conditions that were under the apartheid regime and its lasting impact (Laher & Cockcroft 2013, p. 3). One could argue that psychological tests are not designed to accommodate diversity in culture, language, and values (Pateson & Uys, 2005, p. 11). Instead, these tests tend to promote the Western culture in which they were developed. This is particularly evident in the fact that few tests have been specifically created with the South African population in mind.

Psychological assessment is essential despite the challenges it brings. To understand its importance, we should first understand the role of assessment. Testing enables us to make informed decisions about an individual's functioning by providing necessary information that may not be readily available (Pateson & Uys, 2005, p. 11). Testing or assessment would not be necessary if all the required information for an informed decision were readily available. When it comes to assessing the maturity and capability of children, crucial information is often missing. Therefore, it is essential to conduct tests to determine if a child can consent to medical treatment. The question that arises is, if we don't conduct maturity and mental capacity assessments, what other reliable alternatives do we have to achieve the same purpose? Unfortunately, subjective assessments may be used without a more reliable alternative, but this approach also comes with its own challenges. Therefore, despite criticism, Laher & Cockcroft (2013, p. 3) maintain that psychological assessments remain more reliable and valid than any of the limited

alternatives available in South Africa. Therefore, standardised assessments still have a significant role to play in ensuring informed decisions regarding children's capacity to consent.

Psychological testing is crucial for assessment worldwide. Experts believe we should focus on creating valid and reliable tests for multicultural societies (Laher & Cockcroft, 2013, p. 3). The question is not whether we should assess but how to ensure fairness in a multicultural context. In South Africa, testing is conducted daily and serves essential purposes in education (Setshedi, 2008) and child justice (Schoeman, 2006). In educational settings, where resources and space for learners with special educational needs are limited, it is essential to have a standardised approach to ensure that only children who will benefit from these facilities are accommodated (Setshedi, 2008, p. 45). Furthermore, as the diagnosis of learning barriers can significantly impact children, it is important to ensure objective and evidence-based assessments of children. In this context, psychological assessments remain the best alternative to other options.

In the criminal justice system, psychologists and psychiatrists are still asked to provide evidence of children's criminal capacity as it is considered a more valid measure than any other available alternatives (Schoeman 2016, p. 36). The Child Justice Act 75 of 2008 (hereinafter referred to as CJA) requires psychological assessment to determine the criminal capacity of children. Section 11(3) of the CJA stipulates that “the inquiry magistrate may order a report by a suitably qualified person, which must include an assessment of the child's cognitive, moral, emotional, psychological, and social

development”. Section 97(3) identified clinical psychologists and psychiatrists as the most suitable people to conduct criminal capacity assessments. It has been found that there is a lack of consideration for aspects such as “children's cognitive, moral, emotional, psychological, and social development” in the reports compiled by probation officers (Schoeman 2016, p. 36). Hence the need for psychological assessments.

In conclusion, when conducting psychological assessments in a multicultural context like South Africa, it is crucial not to rely solely on traditional testing approaches. Amod & Seabi (2013, p. 120) advocate for a dynamic form of assessment with an active relationship between the assessor and the test taker. Dynamic assessments require tests that can be used and interpreted qualitatively within the guidelines to ensure consistency and fairness (Amod & Seabi 2013, p. 120). This qualitative interpretation relies on the skills and competencies of practitioners to provide appropriate recommendations (Amod & Seabi 2013, p. 120) regarding the child's capacity to consent. It can also offer valuable insight into the child's perspective on their medical condition, guiding the implementation of support mechanisms during treatment. However, it will still require conceptualisation of what needs to be measured. Then, the appropriate tests can be identified, adapted, and re-normed to serve the purpose.

CHAPTER 4

Children's right to consent to medical treatment.

4.1 Introduction.

In this chapter, I argue that Section 129(2), in its current form, has the potential to infringe upon children's right to autonomy. I will present the perspective of literalists who believe that the law should be adhered to as stated if it is unambiguous. Through this perspective, I will demonstrate that Section 129(2) is unclear and ambiguous and may violate children's right to autonomy. I will also supplement this argument with the perspectives of contextualist and mischief approach which requires us to consider the broader context when interpreting the law.

To support this argument, I will first examine the legal basis of children's rights in South Africa. This will be followed by analysing how the law is interpreted to determine the legislature's intention. To strengthen my argument, I will then explore the notion of informed consent, which can be seen as a manifestation of an individual's self-determination in matters related to healthcare. I will conclude by highlighting that under Section 129(2), the ability of children to provide informed consent for medical treatment is linked to their mental capacity and maturity. This implies that healthcare professionals must assess a child's mental capacity and maturity before determining whether they can provide informed consent for medical treatment. I contend that linking a child's autonomy to the outcome of this assessment could potentially infringe on their right to autonomy within the legal framework of South Africa. The current law does not address two crucial

issues: Firstly, the law does not offer a precise explanation of what qualifies as “sufficient maturity”. This raises the question of what maturity is and how it can be assessed in a diverse and multicultural society like South Africa. Secondly, it does not indicate who should assess children's maturity and mental capacity.

5.2 Legal framework of children’s rights to autonomy in South Africa.

Children's rights have been long recognised in South Africa. The country has a history of global leadership in improving children's rights, dating back to the 1924 and 1959 Geneva Declarations (Binford 2016, p. 341). However, the implementation of apartheid policies in South Africa led to a series of ongoing violations of human and children's rights. These severe violations eventually caused the country to become increasingly isolated from the international community (Binford 2016, p. 342). It was after the 1994 democratic elections that South Africa reintegrated with the international community. During this time the country became a signatory of international and regional agreements such as the 1989 “UNCRC” and the 1990 “African Charter on the Rights and Welfare of the Child (ACRWC)” (Binford 2016, p. 342).

The UNCRC and ACRWC emphasise the significance of respecting children's growing independence and “involving them in decision-making processes” regarding medical treatment. However, Hein et al. (2015, p. 2) highlight that while these agreements advocate for children's participation in decision-making, there is no universal consensus on the age at which minors should be deemed capable of making informed decisions about medical treatment. Despite the absence of international agreement on the

appropriate age for children to make medical decisions, it is widely acknowledged that a child's capacity to form opinions cannot be solely determined by their age (Kruger 2018, p. 14). This is because children differ significantly in terms of their development. Therefore, using age as the sole determinant of their maturity might be problematic as other children might reach certain developmental milestones earlier or later than others. Additionally, maturity is also influenced by several other factors such as “exposure to information, life experiences, surroundings, social and cultural expectations, and support levels” (Hein et al 2015, p. 4). In South Africa, the Constitution, the National Health Act, and the CA all safeguard children's right to autonomy in medical decision-making.

a) The Constitution of the Republic of South Africa

The Constitution aligns with the Universal Declaration of Human Rights, which affirms that “everyone is born free and equal in dignity and rights”. Section 7(1) of the Constitution establishes the Bill of Rights as a fundamental component of the country's democratic system. It protects the rights of all people, including children, and “upholds the democratic values of human dignity, equality, and freedom”. Section 9 ensures that every person is entitled to “equal treatment before the law”. This includes “equal protection and benefit of the law”, without any form of discrimination. Sections 9(3) and 9(4) explicitly prohibit any “unfair discrimination based on a non-exhaustive list of grounds” such as age.

Section 28 explicitly outlines the rights of children. However, children are entitled to all the rights enumerated in the Bill of Rights, not limited to those emphasised in Section 28 (Skelton 2019, p. 560). The courts have recognised the importance of upholding all

constitutional rights for children and have applied other rights to children in cases such as *S v Williams and Others 1995 (3) SA 632 (CC)* and *Christian Education South Africa v Minister of Education 2000 (4) SA 757 (CC)*, even though they are not explicitly included in Section 28. The health-related right to autonomy is protected under Section 12 of the Constitution and is particularly important in this paper. According to Kruger (2017, p. 18), although the South African Constitution does not explicitly grant autonomy rights, individuals are conferred with such rights through section 12(2) which relates to the body's integrity.

b) The National Health Act

The National Health Act (hereinafter referred to as the NHA) outlines patients' rights regarding informed consent in healthcare. Sections 6, 7, and 8 of the NHA state that patients have the right to be fully informed about their health status, must provide informed consent for any treatment, and should also be involved in all decisions related to their health. Section 6(2) also mandates that healthcare providers communicate with patients in a language they understand and in a way that considers their literacy level. For children, du Preez (2011, p. 7) highlights that healthcare professionals should be mindful of using child-friendly language and consider their level of understanding to ensure that the message is clear and children can comprehend it.

c) The Children's Act

The CA is a law that is supposed to focus comprehensively on legal issues related to children. However, I highlight that certain aspects of the Act may not be explicitly detailed,

leaving room for interpretation and potentially limiting its effectiveness in protecting children. Prior to the implementation of the CA, matters relating to children were addressed through a variety of laws, resulting in inconsistent prioritisation of the best interests of the child (Du Preez, 2011, p. 7). Section 129(2) addresses the issue of children's consent to medical treatment. It is important also to note Sections 7, 9, and 10.

Section 9 underlines the significance of prioritising the “child's best interests in all matters” related to their care, protection, and well-being. Section 10 further emphasises the consideration of a child's views in accordance with “their maturity and stage of development”. Additionally, Section 7 delineates the various factors that need to be considered when applying the “best interests of the child standard”. These factors encompass the consideration of the child's maturity and mental capacity in relation to medical treatment. Sections 7, 9, and 10 are connected to Section 28(2) of the Constitution, which highlights the “paramount importance of the child's best interest” in any decision involving them. The inclusion of these sections emphasises the importance that the law places on safeguarding children's interests in all matters concerning them. I will thoroughly explore this principle in section 5.5, highlighting its significance in assessing a child's ability to consent to medical treatment.

5.3 Interpretation of statutes

Children's rights in South Africa are constitutionally protected. It is Kilkelly & Liefaard’s (2019, p. 524) view that including children's rights in the constitution was a significant legal milestone for South African children as it provided them with greater protection. As

per Kilkelly & Liefaard (2019, p. 524), the courts are vital in protecting children's rights. Therefore, to comprehend how the law is enforced, it is crucial to analyse how the legal rules are interpreted by the judiciary. Jaars (2021, p. 3) describes the interpretation of statutes as involving “the application of rules and principles to determine the accurate meaning of the legislative text in legal disputes”. There are three main ways to interpret statutes that have been applied in South Africa: the mischief rule, textualist, and contextual approach (du Plessis 2002, p. 102).

a) Mischief approach to legal interpretation

The mischief rule is a legal principle where the court interprets the language of a statute in the context of the problem that the statute aims to resolve (du Plessis 2002, p. 102). In the mischief approach, the law seeks to answer the question of what the mischief is that the law or piece of legislation sought to resolve (du Plessis 2002, p. 102). In relation to Section 129(2), the application of the mischief rule necessitates an examination of the harm that existed before the law was enacted, which the law now aims to address or rectify. However, throughout the 20th century, legal interpretation in South Africa has predominantly favoured the textualist approach, often relegating mischief and contextual considerations to the background (Perumalsamy 2019, p. 11). However, the judgment in the *Natal Joint Municipal Pension Fund v Endumeni Municipality 2012 (4) SA 593 (SCA)* (hereinafter referred to as Endumeni) has brought to light a notable shift towards a more contextualist approach.

b) Textualist interpretation of legislation

The textualist approach holds that legislation's plain or ordinary meaning is usually the most important determinant of its legal meaning (du Plessis 2002, p. 102). The textualism approach considers other factors, such as the broader context, as less important and should only be considered when a word is unclear, unreasonable, or ambiguous (Perumalsamy 2019, p. 11). The primary goal of interpreting legislation is to comprehend the typical meaning of a word or phrase initially. If the typical meaning is unambiguous, it should be applied. However, if the meaning is unclear, unreasonable, or ambiguous, the interpretation may differ from the ordinary meaning to represent the intended meaning by the legislature (du Plessis 2002, p. 102).

c) Contextualist approach to legal interpretation

The contextualist approach is the third approach to legal interpretation. This approach differs from textualist in that instead of focusing only on the words used in the legislation, it focuses on the context against which the words have been used (du Plessis 2002, p. 102). Perumalsamy (2019, p. 6) explains that the contextual approach to legal interpretation has been around for a while but has always been considered secondary to textualism. The significance of contextual interpretation can be traced back to Judge Schreiner's stance in the case of *Jaga v Donges 1950 4 SA 653 (A)*. Schreiner J held that the meaning of a specific word is reliant on its context. Therefore, the interpretation of words should always be based on the context in which they are used, rather than relying solely on context when uncertainty arises. Schreiner also emphasised the need to consider intention, background, and practical implications beyond the legal context when

examining interpretations. This signified a shift in the interpretation of legislation away from a pure textualist towards a more contextualist approach (Wallis 2019, p. 21). However, it was not until the judgment by Judge Wallis in *Endumeni* that the courts started to embrace Scheiner's approach.

5.4 Informed consent and autonomy in medical decision-making.

Beauchamp and Childress (2001, p. 125) define autonomy as an individual's ability to make independent decisions without external influences. In medical decision-making, autonomy is demonstrated through informed consent, which recognises an individual's right to self-determination and freedom of choice (Beauchamp and Childress 2001, p. 125). Informed consent is a legal concept based on the "ethical principle of respecting an individual's autonomy" (Chima, 2018, p. 2). According to Akpa-Inyang and Chima (2021, p. 3), obtaining consent for medical treatment involves a "collaborative decision-making approach that emphasises the principles of autonomy and beneficence within the doctor-patient relationship". In essence, it is crucial to involve patients in the decision-making process and ensure their autonomy is respected, while also considering what is in their best interest.

In South African law, the principle of patient autonomy finds its roots in *Castell v De Greef 1994 (4) SA 408 (C).* This case centred on the issue of whether a medical practitioner could be held liable for negligence if they failed to disclose the potential risks and complications associated with a surgical operation or other medical treatment to their patient. The central question was whether the focus should be on the patient's right to

make their own decisions or on the medical profession's right to determine what should be disclosed to the patient. The Full Bench of the Cape Provincial Division of the Supreme Court, as it was then, ruled that medical practitioners must obtain informed consent from patients before any medical treatment or intervention, thereby emphasising the patient's rights of autonomy and self-determination.

In the Castell case, it was highlighted that for a patient's consent to validate the legality of medical treatment, the doctor must ensure that:

> "The patient is informed about any significant risks associated with the proposed treatment. A risk is considered significant if: (a) a reasonable person in the patient's position would find it important if informed, (b) the medical practitioner knows or should reasonably know what information the patient finds important if informed" p. 426 [C].

When it comes to children and their medical care, it is crucial to consider what information a reasonable child would want to know and how the doctor should effectively communicate it to the child. Health professionals are obligated to prioritise the best interests of the child when making such decisions. When determining what the average child would want to know, one must consider Section 7 of the CA, which specifies that the "child's age, maturity, and stage of development" should be considered, along with any "chronic illnesses, the child's emotional and physical well-being", when applying the best interest of the child.

According to Chima (2018, p. 3), when obtaining consent from a child, the healthcare provider should furthermore consider the child's level of maturity, cognitive abilities, educational background, and belief system, as these factors can significantly impact the child's capacity to understand the information needed to give consent. However, one should note that even if all the relevant information is provided, how it is communicated to the child could still hinder decision-making (Du Preez 2011, p. 4). In this situation, the significance of the clinician's expertise and their ability to communicate with compassion and understanding cannot be overstated. Du Preez (2011, p. 4) highlights that the CA does not specify how information should be communicated to the child, nor does it address potential biases of the attending medical practitioner or mandate an impartial practitioner to aid the child in their decision-making. Du Preez (2011, p. 5), therefore, cautions that if the presentation of information overshadows the actual content of the information, the child may still struggle to form a proper judgment about what is being conveyed.

5.5 Best interests of the child principle.

The legal system in South Africa places utmost importance on prioritising “the best interests of the child” under Section 28 of the Consitution. This emphasis is influenced by the UNCRC, which recognises the “human rights of children in all aspects of their lives” (Kilkelly & Liefaard, 2019, p. 524). When interpreting the Bill of Rights, the courts have the “authority to consider international law” under Section 39(1)(b) of the Constitution. This enables the courts to refer to various instruments, including the UNCRC and the ACRWC in cases involving children's rights. Therefore, understanding the best interest of

the child principle involves considering General Comment 14 of the UNCRC, which outlines the principle as a threefold concept (Kilkelly & Liefaard, 2019, p. 524).

Firstly, the principle of a “child's best interests is a substantive right”, ensures that every child's welfare is taken into consideration in any matters concerning them (Skelton 2019, p. 560). Section 28(2) of the constitution contains a standalone best interest clause, emphasising that "A child’s best interests are of paramount importance in every matter concerning the child." This sets it apart from the UNCRC, which mandates “the consideration of the best interest of the child in every matter concerning them”. The South African Constitution's emphasis on the “paramount importance of the child's best interests” underscores the significance of this principle in the country's legal system. This was further emphasised by Sach J in *S v M 2008 (3) SA 232 (CC),* where he indicated that "the paramountcy principle requires that the interests of children are given the weight they deserve…as they are of the highest value according to the law".

Sections 7 and 9 of the CA furthermore stress the paramount importance of considering “the best interest of the child” in all decisions and actions undertaken by any individual or authority, where the child is concerned. Section 7 goes a step further to delineate various factors that should be considered when determining what would be in “the best interests of the child”. In the context of medical treatment, it is crucial to consider the “child’s age, level of maturity, and stage of development, as well as their emotional and physical well-being, and their emotional, intellectual, cultural, and social development”, while considering any disability or chronic illness they may have.

Secondly, the "best interest of the child" principle is an important rule that guides decision-making processes concerning children (Skelton 2019, p. 560). This principle requires that any decision about a child considers the potential impact on the child. It helps us understand how the law is likely to interpret any matter brought before it concerning a child. Lastly, the best interest of the child principle is an interpretive principle used to determine whether a legal provision is favourable to children (Skelton 2019, p. 560). It is du Preez's (2011, p. 4) view that at the time when "South Africa had the highest HIV/AIDS infection rates in the world", Section 129(2) provided access to healthcare because it eliminated the requirement for parents to have jurisdiction over children older than twelve in relation to medical treatment.

5.6 Interpretation of Section 129(2) and children's rights to autonomy.

a) Textualist interpretation of Section 129(2).

Interpreting legislation through textualism involves analysing the words used in the relevant law to determine their unambiguous meaning. According to the Merriam-Webster Dictionary (2024), ambiguity refers to a word or expression that can be understood in multiple ways. When a word or expression is ambiguous, it allows for several interpretations, which leads to a lack of clarity and understanding. The Legal Information Institute (2021) defines ambiguity as a state of vagueness or uncertainty in meaning, where an expression can be interpreted in more than one distinct way. In the context of interpreting laws, ambiguity refers to the doubt a judge must entertain before searching for or applying a secondary meaning (Legal Information Institute 2021).

Legal Information Institute (2021) highlights two types of ambiguities - patent and latent. Patent ambiguity is evident in the language of a document itself, and it is open to interpretation. In contrast, latent ambiguity is less obvious, and it arises from a “collateral matter when the document's terms are applied or executed” (Legal Information Institute 2021). Thus, latent ambiguity can make it challenging to understand the intended meaning of a document, and it requires extra care and attention to resolve (Legal Information Institute 2021). Ambiguous words used in legislation can be a challenge to the rule of law as it makes it difficult for people to comprehend the intended meaning and how it should be enforced. According to Donen (2020, p.1), for the rule of law to be effective, it must be clear, logical, and deserving of respect, not arbitrary, and people must understand its requirements. Donen (2020, p.1) further argues that upholding the rule of law is crucial for protecting human rights and achieving fundamental freedoms.

Section 129(2) stipulates that a child who is 12 years old or older and possesses the “maturity and mental capacity to understand the implications of medical treatment” may provide consent. However, this leads to latent ambiguity in three ways. Firstly, it is uncertain who is responsible for evaluating the child's maturity and mental capacity for consent. This lack of clarity poses a challenge as it is unclear whether it is the duty of the treating medical professional to assess the child's mental capacity to consent or if another health professional is tasked with this determination. According to McConnachie et al. (2017, p.1), with every right comes a corresponding duty. This implies that if a child has the right to consent to the medical treatment given their maturity and mental capacity,

someone else is legally obligated to assess these. Yet, it remains unclear whose responsibility it is to carry out this task as the CA does not address this issue.

Furthermore, Section 7(2) of the Constitution mandates “the state to respect, protect, promote, and fulfil the rights in the Bill of Rights”. If it is unclear who is responsible for assessing children's maturity and mental capacity, it could violate their right to autonomy in two ways. Health professionals may provide medical treatment to children without first assessing their maturity and mental capacity to consent. This is because they believe that evaluating children's maturity and mental capacity is beyond their scope of practice and they do not have sufficient expertise in that area. This could result in inconsistent assessment measures being applied to children, leading to challenges in terms of the validity and reliability of such assessments. Additionally, it could lead to health professionals conducting assessments based on their experiences, rather than on formal training, potentially compromising the quality of the assessments.

The second challenge is that it is not clear whether health professionals need to evaluate both maturity and mental capacity to determine a child's ability to give consent, or if only one of these factors is sufficient. It seems that the way Section 129(2) is presented implies that maturity and mental capacity might be interchangeable or evaluated similarly. If this is the case, why do we need to consider both factors in the act? This remains unclear. On the other hand, if they have different meanings, what is the reasoning behind requiring both to be present? In cases where a child may be considered mature enough but lacks the mental capacity to give consent, how should health professionals resolve the

situation? Should the child be allowed to consent, or should they be deemed incapable of consenting, requiring parents or guardians to consent on their behalf? This presents a challenge in implementing ambiguous legislation as it creates difficulties for health professionals and the public alike.

The vague nature of Section 129(2) may result in healthcare professionals interpreting the requirement differently, leading to inconsistent implementation of the law (Havenga & Temane 2016, p. 2). This goes against Section 4 of the CA, which states that the act should be implemented in an integrated, coordinated, and uniform manner by all applicable spheres of government. Inconsistent implementation of Section 129(2) could potentially infringe on children's autonomy rights, as it would be difficult to determine if they have the necessary “maturity and mental capacity to understand the benefits and consequences of the proposed treatment”, which is a crucial requirement for exercising their autonomy rights.

To prevent public confusion, health professionals must apply Section 129(2) consistently. Inconsistencies in their conclusions about a child's ability to consent can lead to a lack of trust in their expertise as public servants and the rule of law (Culver 2004, p.110). A fundamental principle of the rule of law is that it should be applied equally and without unjustifiable differentiation (Crossley 2020, p. 477). Therefore, ensuring consistency, efficiency, and social justice in the application of the law is critical to maintaining public trust (Crossley 2020, p. 478). Le Roux (2019, p. 4), therefore, emphasises the urgent

need for greater consistency, efficiency, and social justice in the application of the law to avoid any confusion and to ensure that the rule of law is implemented correctly.

Lastly, the terms "maturity" and "mental capacity" are not defined in the CA, creating confusion as it is difficult to determine their meaning in the context of the law and how they should be assessed. To interpret and understand maturity and mental capacity in the legal context, I will explore various definitions, starting with the dictionary definition of maturity and mental capacity, and then delve into more technical definitions in terms of psychology and law. The Merriam-Webster Dictionary (2024) provides two definitions of capacity: in legal terms, it defines capacity as referring to individual competence and provides an example of personal capacity to stand trial. In psychological terms, capacity is referred to as the individual mental ability to carry out a certain task. Legal Information Institute (2021) defines capacity as “the ability to make a rational decision based on all relevant facts and considerations”.

Maturity, on the other hand, is defined by the Cambridge Dictionary (2024) as “the quality of behaving mentally and emotionally like an adult”. According to Daly (2020, p. 2), the word capacity in a health context is often used interchangeably with competence “to describe one's cognitive abilities or mental processes, such as knowing, judging, and evaluating”. However, it is important to note that there are two elements of capacity, according to (Daly 2020, p. 2): legal capacity, referring “to the standard for someone to make legally effective decisions,” and mental capacity, which refers to “judgments about decision-making skills.” The textualist approach focuses on interpreting statutes based

on the plain meaning of the words. However, the broad definitions of terms like "maturity" and "mental capacity" present challenges for health professionals when conducting assessments. It is unclear which specific aspects of these constructs need to be assessed and the appropriate assessment methods. Dictionary definitions also provide limited assistance in understanding the meaning of these terms.

The lack of definition is further complicated by the lack of professional consensus on what maturity and mental capacity entail and how to measure them (Pillay & Willows, 2015, p. 98). The implications of this are extensive in terms of professional honesty, which is a crucial ethical aspect in the healthcare field. This matter should be examined in the context of increased medical negligence cases in South Africa. Culver (2004, p.110) warns that vague legal standards can disrupt the promise of the rule of law by affecting people's expectations of the future legal consequences of their actions. The fear of being sued may cause healthcare providers to conduct unnecessary assessments of children's mental capacity that may not be beneficial to children and could be expensive for the healthcare system (Malherbe, 2013, p. 83). This can lead to defensive medicine practices by health professionals who aim to demonstrate to the legal system that the appropriate standard of care is maintained (Malherbe, 2013, p. 83).

b) Contextualist Interpretation of Section 129(2).

The contextualist interpretation of legislation suggests that we should consider the meaning of words in the context in which they are used when interpreting any legislation. According to Judge Schreiner in the Jaga case, examining the context goes beyond the

enactment itself and considering “the purposes, background, and practical consequences of each interpretation compared to others”. To understand Section 129(2), we should consider the context and the purpose of the act along with the background of psychological assessment in South Africa. In 1995, the government of South Africa recognised the existence of "racial discrimination and inequalities" in the Child Care Act 74 of 1983 (hereinafter referred to as CCA) (September 2014, p. 141). According to September (2014, p.141), the South African Law Commission undertook a comprehensive review of the legislation, primarily focusing on promoting equality and safeguarding children's rights. Subsequently, a new and improved CA was formulated due to this rigorous review process. The current CA places a strong emphasis on prioritising the best interests of the child, upholding their constitutional rights, and protecting against maltreatment, abuse, neglect, and degradation.

Section 129(2) exists to uphold children’s right to autonomy in medical treatment. To ensure these rights are protected, and decisions made are in “the best interest of the children” (Section 9 of the CA), it requires that children have “sufficient maturity and mental capacity to understand the benefits and the consequences of the proposed treatment”. Therefore, assessing children's maturity and mental capacity becomes the basis of their consent. However, this becomes a challenging task for two reasons. Firstly, there are currently no established assessments of children's maturity and mental capacity that could enable them to consent to their treatment. Secondly, there are no guidelines guiding health professionals' actions on how maturity and mental capacity assessments should be conducted.

It's crucial to consider that historically, the main challenges of the now-repealed CCA were associated with discrimination and inequality. This raises concerns about whether Section 129(2) upholds children's constitutional rights to equality and non-discrimination without clear guidelines and standardised assessment tools. Inconsistencies in applying the law could result in discrimination against certain children due to the complexity of the concept of maturity (Hein et al., 2015), especially in an unequal society like South Africa with uneven resource distributions (UNICEF, 2011). According to the review conducted by the UNICEF and South African Human Rights Commission (2011, p. 128), a significant gap exists between children growing up in the richest and poorest quintiles in South Africa. Children in the poorest quintiles are less likely to have access to early childhood education, complete secondary school, or have medical aid, relying instead on the public health system (UNICEF, 2011). These factors are important in assessing children's maturity, as it's not solely determined by age but also influenced by factors such as an individual's background, exposure to information, life experiences, surroundings, and support levels (Hein et al., 2015, p. 4). This implies that children raised in wealthier areas, with access to favourable conditions such as information, a strong support system, and quality healthcare (UNICEF, 2011), may be perceived as more mature. Meanwhile, children raised in poor areas, with unfavourable conditions, including poor surroundings, lack of support, and information (UNICEF, 2011), may be seen as lacking maturity. This contradicts the constitutional values of South Africa, which aim to safeguard children's constitutional rights to equality and non-discrimination and ensure their best interests are protected in healthcare.

In addition, any actions involving children should align with Section 28 of the Constitution, which emphasises that “the best interests of the child should be of utmost importance in all matters concerning them”. I argue that Section 129(2) does not prioritise the best interests of the children, potentially infringing on their right to autonomy. Despite the CA being in effect for over a decade, there are still no established, evidence-based standards for assessing children's maturity. While Section 129(2) seems to address the important issue of children's right to health, without clear implementation guidelines, it is likely to be ineffective (du Preez 2011, p.5). This is because a significant aspect of respecting children's right to make decisions about their health relies on healthcare professionals' judgment of their maturity and mental capacity. According to Bango-Rili (2021, p. 21), considering the factors listed in Section 7 of the CA can help healthcare providers determine if a child has the maturity and mental capacity to provide informed consent. Section 7 outlines various factors to consider when determining what would be in "the best interests of the child". In the context of medical treatment, these include “the child's age, level of maturity, stage of development, emotional and physical well-being, as well as their emotional, intellectual, cultural, and social development, and any disability or chronic illness the child may have”. I contend that simply taking these factors into account is inadequate as it fails to offer guidance on determining a child's maturity and mental capacity. We need to address how we can objectively establish that a child has the maturity and mental capacity to consent, and how we can ethically and legally justify our conclusion. Additionally, we require objective assessment tools that can be consistently applied by all health professionals to make appropriate judgments about a child's maturity.

c) Mischief Rule interpretation of Section 129(2).

The court applies the mischief rule when legislation cannot be interpreted literally. This occurs when the wording of the legislation is unclear, making it challenging to understand its meaning based solely on a literal reading (du Plessis 2002, p. 101). In such instances, the courts may employ a purposive approach to interpretation, aiming to identify the underlying issue that the law seeks to address and provide the appropriate remedy (du Plessis 2002, p. 102). In using the purposive approach, the courts consider the law that existed prior to the relevant legislation, the "defect in that legislation, the remedy that Parliament introduced, and the purpose behind that remedy" (du Plessis 2002, p. 102). The mischief that the current CA sought to address was the discrimination and inequality in the previous CCA. This Act was inconsistent with the “democratic values of human dignity, equality, and freedom” (September 2014, p. 141). In the case of *Fraser v Children’s Court, Pretoria North, and others 1997 (2) SA 261 (CC),* it was found that Section 18(4)(d) of the CCA, which mandated the consent of both parents before issuing an adoption order for a legitimate child, was unconstitutional as it violated the right to equality and discriminated against fathers based on their gender or marital status.

Similarly, in the case of *Minister of Welfare and Population Development v Fitzpatrick and Others 2000 (3) SA 422 (CC), it was held that* Section 18(4)(f) of the CCA, which prohibited the adoption of a child born in South Africa by non-South Africans, was inconsistent with Section 28(2) of the Constitution, as it did not prioritise the best interests of the child in every matter concerning the child. Furthermore, Proudlock and Jamieson (2010, p. 31) identified two issues with the provision of social services in the CCA. Firstly,

it maintained an outdated residual approach that focused on state protection services for children only after they had been abused, with no provision for prevention and early intervention services. Secondly, the CCA did not legally obligate the state to provide any social services for children, as all the provisions in the Act were framed in discretionary language (Proudlock & Jamieson 2010, p. 31). It was against this mischief that the current CA was introduced; to remedy the past inequalities and discrimination. Therefore, this was done by developing a CA that aligns with the constitutional values and principles of equality, dignity, and freedom.

Chapter 5

Ethical concerns relating to assessing children's right to consent.

5.1 Introduction

Ethics are integral to the healthcare profession. In this chapter, I delve into the ethical principle of respect for autonomy regarding children's rights to consent to medical treatment. Children while recognised as individuals with rights, occupy a unique position in the moral and legal community (Godwin 2020, p. 309). Their needs and interests deserve respect, but their rights are limited when coming to medical treatment as compared to adults (Schapiro 2003, p. 576). They cannot consent to their medical treatment unless they have sufficient maturity and mental capacity. In this chapter, I will explore the current provisions within Section 129(2) and evaluate whether they are ethically justified, given the complex moral status of children.

The chapter first examines theories of moral status, using a cognitive capacities theory. Section 129(2) discusses children's maturity and mental capacity to consent to treatment. Mental capacity in this context refers to children's cognitive ability to understand the benefits and consequences of the proposed treatment, aligning with cognitive properties in moral status theory. The argument is that children can be considered moral agents only if they possess the rationality and higher-order thinking needed to comprehend the benefits and consequences of the proposed treatment. Thus, assessing maturity and mental capacity is essential before children can consent to medical treatment unilaterally.

Additionally, it explores whether Section 129(2) could violate children's rights when viewed through the ethical perspectives of Utilitarianism and Kantian Deontology. Utilitarianism aims to maximise overall utility for the greatest number of people. When applying this perspective to Section 129(2), it is crucial to balance the need to assess children's mental capacity and maturity with the broader community's health needs. The utilitarian argument focuses on whether these investments will result in greater overall benefits compared to improving mental health facilities for the broader community.

Looking at Section 129(2) through the lens of Kant's Deontology, the lack of an objective assessment that can be consistently applied to all children contradicts Kant's categorical imperative principle. According to Kant, we should only act on principles that could be universalised. If health professionals apply Section 129(2) inconsistently, then this violates Kant's principle of universality. Therefore, without clear guidelines and objective assessment tools that can be applied consistently to all children, Section 129(2) is not ethically justified by Kant's deontology.

5.2 Foundations of Medical Ethics

Normative ethics is a philosophical branch that focuses on defining what is right and wrong (Tseng & Wang 2021, p. 1). Its main goal is to establish clear definitions for terms that guide human behaviour, such as duty, and obligation (Driver 2009, p. 31). Medical ethics refers to a set of moral principles, values, and beliefs that govern medical practice (Tseng & Wang 2021, p. 1). In medicine and healthcare, professional morality establishes moral standards that guide medical values and behaviours. These principles guide ethical

decision-making, enabling healthcare professionals to make decisions consistent with their values and beliefs (Varkey 2021, p. 2).

The history of medical ethics can be traced back to the Hippocratic Oath, physicians pledge to deal with ethical dilemmas or conflicts that may arise in a healthcare setting (Tseng & Wang 2021, p. 1). During World War II, inappropriate treatment and mistreatment of human subjects in medical experiments, which included conducting medical interventions without informed consent and experimentation in concentration camps, led to The Belmont Report (Varkey 2021, p. 3). This report introduced principled ethics to ensure biomedical safety and patient rights (Tseng & Wang 2021, p. 1). The Belmont Report presented three core principles: autonomy, beneficence, and justice. Beauchamp and Childress later expanded on the Belmont report and introduced the "principlism" framework a commonly used method for analysing medical ethics to this date (Varkey 2021, p. 3). This approach involves weighing and judging four basic moral principles: doing good (Beneficence), avoiding harm (Non-Beneficence), respect for autonomy, and justice and considering their scope of application (Misselbrook 2015, p. 55).

5.3 Understanding Moral Status

In modern ethics, a significant question revolves around which entities should be considered to have moral status (Timmer 2023, p. 2). Having moral status entails being safeguarded by moral norms that guide individuals' behaviour. This significantly influences how an entity should be treated, and what legal, political, social, and economic

systems should be established to respect it (Timmer 2023, p. 2). There are two primary reasons why an entity might be said to have moral status. The first reason is based on the idea that the entity possesses a certain status property (Beauchamp & Childress 2009, p. 67). Various theories of moral status focus on how individuals acquire moral status. Some believe that entities gain moral status if they possess certain human or cognitive properties or have moral agency (Beauchamp & Childress 2009, p. 67). Others focus on sentience or relationships (Beauchamp & Childress 2009, p. 67). The theory that I will focus on in this paper is the one that accords an individual's moral status based on their cognitive properties. Section 129(2) focuses on children's maturity and mental capacity, which is related to their cognitive capacities to understand the benefits and consequences of the proposed treatment. The theory of cognitive properties posits that individuals possess moral status due to their ability to reflect on their lives through cognitive capacities and their self-determination based on beliefs, which sets them apart from incompetent humans and nonhuman animals (Beauchamp & Childress 2009, p. 71).

The second reason is that if entities have moral status, they also have a set of rights and interests that are morally important (Timmer 2023, p. 2). This means we have ethical reasons to protect them. In the case of Section 129(2), if the children are assessed to have cognitive abilities to understand the benefits and consequences of the proposed treatment, then they should be allowed to consent to their treatment.

5.4 Philosophical approaches to medical ethics

a) Utilitarianism

Utilitarianism is one of the prominent theories in ethics. Although its primary focus is not on the right to autonomy, it plays a significant role in the current discussion by concentrating on public health policies and resource allocation (Misselbrook 2015, p. 55). Section 129(2) is a public policy, and its proper implementation depends heavily on how scarce resources are allocated to public health. Utilitarianism therefore offers valuable guidance on how it is likely to be implemented; and whether its implementation, is likely to promote or violate children's rights to autonomy. Utilitarianism is a form of consequentialist ethical theory that determines the rightness or wrongness of an action based on its outcomes, weighing the balance of good and bad consequences (Amer 2019, p. 188). Utilitarianism proposes that an action's ethical value is determined by its ability to produce “the greatest utility or good for the largest number of people” (Driver 2022, p. 2). John Stuart Mill and Jeremy Bentham, founders of utilitarianism, define good or utility as pleasure or happiness, and the goal is to maximise this good (Amer 2019, p. 188). To accomplish this, the outcomes of an action are measured by the quantity of utility or happiness it generates for the greatest number of individuals.

In implementing Section 129(2), the main focus of utilitarianism will be on how to maximise the good for the greatest number of people. It is important to note that utilitarianism emphasises impartiality, so everyone's happiness is equally considered (Misselbrook, 2015, p. 55). This means that utilitarians are likely to consider the entire health system and evaluate whether applying Section 129(2) is likely to bring about the

greatest good to most people within the mental health system. A good starting point might be to examine the status of the mental health facilities and the resources needed to apply the provisions of Section 129(2). The focus on mental health facilities is because mental health professionals are best suited to assess children's maturity and mental capacity as alluded to in chapter 2.

According to the 2018 statistics released by the South African College of Applied Psychology, "only 27% of South Africans suffering from severe mental disorders receive the necessary treatment". This highlights a mental health system that is in a state of crisis. Furthermore, Sorsdahl et al. (2023, p. 2) highlighted that "there is currently a severe shortage of trained mental healthcare providers in South Africa", with specialisations such as child and adolescent mental health being neglected. Nguse & Wassenaar (2021, p. 306) shed some light on why mental health facilities might be ailing because they are only "allocated 5% of the national health budget". This situation has led to only "50% of public hospitals offering mental health services having a psychiatrist, and about 30% not having a clinical psychologist" (Nguse & Wassenaar 2021, p. 306).

In the current situation, evaluating the maturity and mental capacity of children to provide informed consent is a complex decision. This decision may lead to two equally undesirable scenarios that could hinder children's right to autonomy. Firstly, the process could divert limited resources from those who need mental health support the most. This could lead to a situation similar to the Life Esidimeni tragedy, where mental health users were transferred to ill-prepared facilities due to cost-cutting measures (Ferlito & Dhai

2018, p.157). On the other hand, due to the shortage of child and adolescent specialists (Sorsdahl et al, 2023, p. 2), the assessment of children's maturity and mental capacity may be overlooked. This could lead to situations where children are either treated without assessing their ability to consent or are required to obtain parental consent (Bester et al., 2018, p. 649). This would well be justified from a utilitarian perspective, as prioritising the long list of mental health patients in need of services over assessing children's mental capacity to consent would maximise utility for the greatest number of mental health individuals. Neither scenario ensures effective implementation of Section 129(2), potentially violating children's right to autonomy.

Utilitarianism is often criticised for prioritising the needs of larger groups over those of individuals or minorities (Misselbrook 2015, p. 55). This means that it is likely to offer little protection for vulnerable or voiceless children in the healthcare system. By prioritising the welfare of society, utilitarian ethics emphasise the importance of outcomes over means (Tseng & Wang 2021, p. 2). This is particularly evident when the consent process involves a thorough evaluation to determine whether the child possesses the maturity and mental capacity to provide consent. It is important to consider this issue in light of the resources available within the country, especially when it comes to mental health services. Although utilitarians aim to prioritise impartiality and overall well-being when allocating healthcare resources (Misselbrook 2015, p. 55), there is still a trade-off that must be made to ensure that resources are distributed in a manner that maximises utility for the greatest number of people. Therefore, given that the mental health budget in South Africa is about 5% of the entire health budget (Nguse & Wassenaar 2021, p. 306), there is a severe shortage

of children's mental health specialists (Sorsdahl et al, 2023, p. 2), utilitarians might view the loss of freedom for some children as made right by a greater good shared by others (Misselbrook 2015, p. 55).

Utilitarianism and paternalism in children.

Historically, the medical field operated under the belief that health professionals should prioritise the patient's well-being over their autonomy. This approach, known as paternalism, assumed that medical experts knew what was best for patients and made decisions on their behalf (Kilbride & Joffe 2018, p. 2). Respect for autonomy on the other hand focuses on shared decision-making and emphasises collaboration between health professionals and patients to make medical choices that align with the patient's values and preferences (Kilbride & Joffe 2018). While paternalism is generally viewed as morally wrong, there are specific scenarios in which paternalism is considered permissible from a utilitarian perspective (Schapiro 2003, p. 576). Godwin (2020, p. 309) believes paternalism is generally considered acceptable for children, as it is often necessary to keep them safe from the negative consequences of their poor decisions. However, it is seen as morally problematic when applied to adults, as they are presumed to have the relevant capacities to make their own decisions Godwin (2020, p. 309). Since paternalism is based on the idea of coercing someone for their good, in the utilitarian view, an intervention can only be justified if it truly benefits the person being coerced and ultimately maximises utility (Godwin 2020, p. 309).

In accordance with Section 129(2), utilitarians might concur that the reason for evaluating children's maturity and mental capacity is to protect them from their immaturity, thereby maximising overall societal benefit. However, they might argue that due to the intricacies of such assessments and the absence of clear guidelines on their administration, this objective is not being met. Consequently, paternalism may be a preferable alternative because it is justified from a utilitarian perspective if it leads to the best outcomes (Godwin 2020, p. 309). Godwin (2020, p. 311) argues that in cases of paternalistic acts, the benefits to the individual must outweigh any potential harm to their interests. This means that if an action causes more harm than good to a child's right to autonomy, it does not fulfil the purpose of paternalism.

According to this framework, health professionals should be the ones to make decisions for children. This is because children, due to their immaturity, are more likely to make poor choices that could significantly impact their overall well-being (Daly 2020, p. 492). The argument could, therefore, be made that using paternalism far outweighs the consequences of assessing mental capacity and an extra burden on the government to provide resources for such assessments. Since there are no standardised tests to be used, each health professional might use intuitive assessments, which might produce correct or incorrect conclusions about children's capacity to consent (Hein et al. 2015, p. 4). As Herring (2016, p. 55) puts it, the consequences of the outcomes of maturity assessments can be far-reaching because if a child is assessed to have mental capacity while they don’t, they could suffer harm and injuries and be told that it was their choice. Similarly, if they are assessed as not having capacity while they do, they could lose their

right to consent to medical treatment (Herring 2016, p. 55). Therefore, Section 129(2) is not ethically justified from a utilitarian point of view because it is likely not to produce overall utility for the greatest number of children in the absence of clear guidelines on how maturity assessments should be conducted.

b) Kantian deontology

Deontological ethics “determines the moral status of an action not by its consequences, but rather by principles such as justice, rights or fairness” (Chukwuneke & Ezenwugo 2022, p. 20). Deontologists believe that certain choices are morally forbidden, and cannot be justified based on their outcomes, regardless of how morally good the consequences may be. One of the most influential deontological philosophers is Immanuel Kant, who views morality as based on our “rational duty to follow correct rules of action” (Misselbrook 2015, p. 53). It is Kant’s view that the rightness of a choice is determined by its conformity with moral norms, which should be followed by every moral agent and not just maximised for individual benefit. In this view, Kant's deontology prioritises what is morally right over what is morally good. If an action does not align with what is right, it should not be carried out, regardless of the potentially positive outcomes it might bring. Kant believes that all our duties can be derived from the “categorical imperative” (Misselbrook 2015, p. 53). The “categorical imperative” is based on the idea that we should only act on maxims that can be made to universal laws (Chukwuneke & Ezenwugo 2022, p. 20).

Kant and Respect for Autonomy.

One of Kant’s significant arguments is his view on allowing only independent individuals to exercise their freedom and free will (Misselbrook 2015, p. 53). According to Kant,

respect for autonomy does not apply to individuals who cannot act independently, such as those who are considered immature, incapacitated, or exploited (Misselbrook, 2015, p. 53). Kant argues that their capacity for rationality sets humans apart from non-human animals (Walls 2008, p. 530). According to Kant, rationality can only be achieved through reasoning that cannot be reasonably disputed by others (Misselbrook 2015, p. 53). However, when it comes to children, Baines (2015, p. 2) argues that children's perspectives and reasoning are often overlooked by significant adults, such as parents or health professionals, and, therefore, cannot be considered autonomous. Walls (2008, p. 530) further argues that the complexity of children's reasoning is also influenced by differences in their maturity. While some children may have the ability for rational and independent reasoning, most of them especially younger children, might lack this capacity.

In examining Kant's perspective on autonomy and the right to self-determination, one might argue that according to Kant, children do not possess the right to autonomy. However, Kant's stance aligns with the current legal position, where children occupy a unique and conflicting position in society (Schapiro 2003, p. 576). On one hand, they have rights, but due to their immaturity, they are excluded from certain legal acts (Kruger 2018, p. 14). Kant believes that children belong to the universal human community and should be treated with dignity and respect (Walls 2008, p. 530), as they possess the potential for rationality and autonomy. Even though children may not be mature enough to carry out certain actions, Kant asserts that they have the potential to develop into fully autonomous human beings (Walls 2008, p. 530), and therefore deserve to be treated with dignity. Thus,

despite their lack of genuine autonomy, Kant insists that children are still worthy of respect and are ends in themselves (Walls 2008, p. 530).

In the medical context where children need to consent, the default position is to first assess their maturity and mental capacity to ensure they understand the benefits and consequences of any proposed treatment. One could argue that this is in line with Kant's belief, that the capacity for rationality gives individuals the right to exercise self-determination. Therefore, it is necessary to demonstrate that children are capable of rationality to comprehend the benefits and consequences of the proposed treatment before they can consent. This assessment is crucial to protect children from making uninformed decisions and to establish if they can provide valid consent. However, the assessment of children's maturity and ability to consent is challenging due to the lack of consensus on how to conduct such assessments (Pillay & Singh 2017, p. 3). This raises the question of whether Section 129(2) supports or undermines children's autonomy rights in the absence of objective assessments. Objective assessments of children's maturity and mental capacity are necessary to ensure fair treatment and respect for their dignity. Even though children may not have autonomy according to Kant's view, they still deserve to be treated with dignity, and objective assessments can help achieve that. However, without a clear method for assessment, it becomes difficult to prove that certain children are capable of exercising autonomy.

Kant and categorical imperatives

According to Ramaswamy (2018, p. 52), the legitimacy of any act in Kant's view can be tested using two categorical imperatives. For an act to be deemed legitimate and permissible, it must be compatible with all two categorical imperatives. If even one of the two imperatives renders an act impossible or redundant, per Kant, the act must not be performed. The first categorical imperative posits that an action should be formulated as a universal law without leading to any contradictions (Ramaswamy 2018, p. 52). Section 129(2) fails to meet this principle for two reasons. Firstly, clear guidelines are essential for the consistent implementation of Section 129(2) nationwide thereby adhering to the principle of universalism. In the absence of guidelines, each health professional relies on their own experience, intuition, and knowledge to determine if children can consent or not (Hein et al., 2015, p. 4)**.** Therefore, guidelines become crucial as they improve the consistency and efficiency of the process, bridging the gap between clinical practice and scientific evidence (Woolf et al. 1999, p. 527). In this way, guidelines ensure that the assessment of children's maturity and mental capacity can be standardised, that health professionals possess the same skills and knowledge, and that assessment measures can be applied consistently.

Secondly, there are no standardised assessment instruments or tools to evaluate children's maturity and mental capacity. This is further complicated by the lack of consensus among health professionals on defining maturity (Pillay & Singh 2017, p. 3). This results in confusion and inconsistency among health professionals in applying Section 129(2). In the absence of objective standardised assessment tools, each health

practitioner relies on subjective assessments to determine whether a child can consent (Hein et al., 2015, p. 4). According to Kant, this subjective approach is morally wrong as it contradicts the maxim of universality. Kant emphasises that health professionals should objectively and consistently conduct assessments, following rational decisions based on objective assessment tools rather than intuitive measures (Kranak 2019, p. 3). Kant's ethical system is based on reason rather than intuition (Chukwuneke & Ezenwugo 2022, p. 20), asserting that a moral person must be a rational being, implying that health professionals should apply rationality in assessing children's maturity, not intuition. Furthermore, in the absence of standardised objective assessments, the law is inconsistently applied, leading to varied approaches among different health professionals. Some provide treatment without assessing the child's consent, while others refuse treatment to children without parental consent (Bester et al., 2018, p. 649).

The second categorical imperative requires that every person should always be treated as an end in themselves, and not merely as a means to an end (Ramaswamy 2018, p. 52). According to Kant, using someone as a mere means occurs when you involve them in a plan of action to which they could not in principle consent (Kranak 2019, p. 3), thus taking away their dignity and self-worth as autonomous agents. Kant emphasises that children belong to the universal human community and deserve to be treated with dignity and respect because they have a rational faculty within them (Wall 2008, 530). Despite their lack of real autonomy, Kant insists that children are still ends in themselves (p. 530). Treating people as an end in themselves provides the foundation that everyone deserves a minimum standard of dignity to sustain human co-existence without coercion

(Ramaswamy 2018, p. 52). Informed consent in this case, therefore, involves the absence of coercion and deception, especially in situations involving a fiduciary relationship such as patient and doctor (Ramaswamy 2018, p. 52).

In his writing on education, Kant emphasised that education is significant in ensuring that people can fully consent and exercise their autonomy (Schapiro 2003, p. 576). Kant argues that lack of education invalidates consent due to a lack of information, affecting a person's ability to exercise their right to autonomy (p. 576). Kant argues that by neglecting to educate children about their rights and restrictions, health professionals fail to treat them with dignity and respect (Schapiro 2003, p. 576). Therefore, Kant suggests that health professionals should educate children about their rights and the importance of assessing their maturity. In this manner, Kant believes that the child's mind is being nurtured to become independent and self-sufficient in the future (Schapiro 2003, p. 576). However, achieving this in the South African context is likely to be complicated. As per a study by Chima (2013, p. 4), language creates a significant obstacle in obtaining informed consent, especially in public hospitals. This issue was recognised when working with the adult population, which has the maturity and mental capacity, and it is likely to be even more challenging when communicating with children.

Healthcare practitioners should be empathetic when dealing with children and use child-friendly language when explaining the treatment procedure. They should consider the child’s age, gender, background, and the emotional impact this news will have on the child (du Preez, 2011, p. 21). It is important to remember that when communicating with

children, it's crucial to ensure that they understand the information being conveyed. This understanding is essential for them to make well-informed decisions. As per Kruger (2018, p. 6), understanding in this context isn't just an abstract process. It also requires grasping the nature and significance of potential choices and incorporating this comprehension into the decision-making process. Kruger (2018, p. 6) emphasises that children frequently lack this level of understanding because of their limited life experience. In these circumstances, it is unlikely that health professionals, due to their workload and time constraints (Chima 2013, p. 4), will have the time to explain and educate children about their rights and responsibilities and why maturity assessments are needed. This therefore fails to uphold Kant's maxim of treating people as ends in themselves thereby infringing on children's right to autonomy.

Kant's view of Section 129(2) presents a challenge regarding how adults should conduct themselves as examples and enforcers of the laws to instil respect for authority in children (Schapiro 2003, p. 576). It suggests that adults should explain rules to children in a principled and fair manner, even if the underlying principles may be too complex for children to fully grasp (p. 576). In the context of Section 129(2), health professionals themselves do not seem to be aware of the existence of this section, which requires them to assess children's maturity and mental capacity (Bester et al., 2018, p. 650) and the reasons behind these assessments. It then becomes challenging when they have to explain to the children the need to assess their maturity and mental capacity and the benefits of such assessments on children. If this is not done, then according to Kant, Section 129(2) will fail in the maxim of not treating people as mere means to an end.

Chapter 6

Summary and Recommendations

6.1 Introduction

This study argued that the current application of Section 129(2) may potentially violate children's right to autonomy due to a lack of clear guidelines on how to assess maturity and mental capacity. This argument was based on the premise that assessing maturity and mental capacity is crucial for ensuring that children can participate in medical decision-making. It argued that given the significance of these assessments, health professionals need to be able to assess children's mental capacity and maturity to consent objectively. Hence, there is a need for clear guidelines to specify how these assessments should be conducted and by whom. I argued that significant questions about who should conduct maturity and mental capacity assessments need to be clarified. Should the treating health professional be responsible for these assessments, or should a specific category of health professionals be tasked with this responsibility?

I therefore argue that it is important to establish a shared understanding of which assessment tools are appropriate for this purpose to guarantee fairness and justice for the children being assessed. This chapter provides a summary of the study and offers recommendations.

6.2 Summary

This study aimed to address the current lack of clarity in the debate regarding children's ability to provide informed consent. It identified a gap in the existing literature, noting that although the topic of children's right to consent has been discussed for decades, there is a lack of clear guidelines on how Section 129(2) should be enforced, potentially infringing on children's right to autonomy. In this study, I argued that without clear guidelines on assessing maturity and mental capacity, children are unfairly disadvantaged by subjective assessment measures, thereby infringing on their right to autonomy in medical treatment. To support this thesis, the study explored the following objectives:

Objective 1: To argue that while most health professionals work with children, not all of them are equally equipped to conduct maturity and mental capacity assessments.

In this section, I delved into the definition of health professionals according to the HPA. I elucidated the challenge associated with using the term "health professionals" in Section 129(2) as opposed to specifying the health professional responsible for assessing children’s mental capacity and maturity. I examined two categories of health professionals relevant to enforcing Section 129(2): healthcare practitioners, who are responsible for providing medical treatment, and psychologists, who are responsible for assessing maturity and mental capacity as per HPCSA's guidelines. I then used the scope of practice provided by the HPA to support my argument as to why psychologists, as opposed to medical doctors, are in the best position to conduct assessments of children's maturity and mental capacity. I further concluded this chapter by highlighting the

implications of ensuring that health professionals act within their scope of practice, as this is linked to their competencies and expertise.

Objective 2: To make a case that lack of standardised assessment measures in children leads to the use of intuitive non-standardised assessments.

In this section, I argued that even though the CA has been in effect for over a decade, it is still unclear which assessment measures are being used to assess the mental capacity of children. This is because no standardised assessments have been developed specifically for this purpose in South Africa. Therefore, I argued how this is not in the best interest of the child, as it leads to the use of intuitive assessments. I also highlighted the ethical challenges related to the use of intuitive, non-standardised assessments and the potential violation of children's right to autonomy in terms of fairness and justice.

Objective 3: To argue that Section 129(2) in its current form is ambiguous and can potentially violate children's right to autonomy.

In this section, I presented the arguments of literalist, contextualist, and mischief approaches to legal interpretation to demonstrate that Section 129(2), in its current form, has the potential to infringe upon children's right to autonomy. I highlighted the perspective of literalists who believe that the law should be followed as stated if it is unambiguous. Through this perspective, I demonstrated that Section 129(2) is unclear and ambiguous and could potentially violate children's right to autonomy. I further supported this view with the contextualist approach, which suggests that the meaning of words should be interpreted in the context in which they are used when interpreting any

legislation. I pointed out that within the multicultural South African context, the use of the words "maturity" and "mental capacity" do not have a single meaning and are likely to be ambiguous due to the diversity of the population being assessed. I reinforced my position by pointing out that interpreting Section 129(2) using a mischief approach could potentially violate children's right to autonomy. According to the mischief approach, which advocates for a more purposive approach to legal interpretation when the literalist approach is not applicable, this is an important consideration. The mischief approach holds that the interpretation of legislation should also consider the mischief present before the current legislation seeks to remedy. I highlighted that in South Africa, where the mischief is related to discrimination and inequality, the current application of Section 129(2) does not do much to remedy this situation. Hence, my argument is that it could potentially violate children's right to autonomy.

Objective 4: To make a case, Section 129(2), in its present state, is not ethically justified when examined from the perspectives of Kant's Deontology and Utilitarianism. Upon analysing Section 129(2) from the perspective of Kant's Deontology, I argued that the lack of an objective assessment that can be uniformly applied to all children goes against Kant's categorical imperative principle. Kant believes that we should only act on principles that could be universalised. If health professionals apply Section 129(2) inconsistently due to a lack of uniform guidelines on how it should be applied, then this violates Kant's principle of universality. I also argued that Section 129(2) is not ethically justified from a utilitarian perspective. Utilitarianism aims to maximise overall utility for the greatest number of people. When applying this perspective to Section

129(2), balancing the need to assess children's mental capacity and maturity with the broader community's health needs is crucial. The utilitarian argument focuses on whether these investments will result in greater overall benefits compared to improving mental health facilities for the broader community. In this case, it will be a utilitarian argument that, when all things are considered, the resources and investments needed to assess children's maturity and mental capacity far outweigh the benefits it brings.

In this final section, I conclude that the potential harm to children's autonomy, caused by Section 129(2) in its current form, creates an ethical need to amend it. As mentioned earlier, due to the lack of standardised assessments to measure children's maturity and mental capacity, uncertainty regarding the health professionals responsible for conducting these assessments, the ambiguity in Section 129(2), and the ethical challenges related to Section 129(2) when viewed from the perspectives of Kant Deontology and Utilitarianism, I make the following recommendations.

6.3 Recommendations

a. Definition of maturity and mental capacity.

It is vital to define maturity and mental capacity clearly and determine how to assess children's maturity and mental capacity. The CA uses the terms sufficient maturity and mental capacity; it will be essential to have these two terms defined within the act to guide how they should be understood and, ultimately, which assessment measures will be relevant. Using the word sufficient also seems problematic as it is difficult to measure; how will health professionals know when maturity is sufficient? There is a need for clarity

as to the reasoning behind the use of that word. Additionally, regarding the use of both maturity and mental capacity, are they synonymous, do they both need to be present, or can either one be considered sufficient? This understanding is crucial for developing assessment tools and is relevant to legal, health, and psychological settings. A clear definition will ensure a common understanding for all involved professionals.

b. Health professionals to assess maturity and mental capacity.

There is a need to clarify which health professionals should be responsible for assessing children's mental capacity and maturity. This assessment should take place within the current healthcare context and financial constraints. Suppose mental health professionals, such as psychologists and psychiatrists, are designated for this task. In that case, we must consider the shortage of these professionals in the county and financial limitations in the mental health field.

Furthermore, it is essential to specify which categories of psychologists should be tasked with this responsibility. Clinical, counselling, and educational psychologists play a role in this assessment. Given the lack of resources in hospital settings, educational psychologists can also assist, as they often work with children who may require accommodations for their learning due to health issues. Counseling psychologists also have a role to play as they focus on development and adjustment difficulties and often work with children. However, clear guidelines are needed to outline the responsibilities of each professional involved and the type of assessment measures suitable for this

purpose. This will help prevent misunderstandings and ensure that other categories of psychologists are not wrongly accused of practicing outside their scope of practice.

c. Development of standardised assessment material.

The lack of standardised material to assess children's maturity and mental capacity in South Africa is critical for adequately implementing Section 129(2). This challenge is magnified by South Africa's multicultural diversity, where cultural norms, languages, and socio-economic conditions can influence a child's development and understanding. To implement Section 129(2) effectively, it is essential to create specific, culturally sensitive assessment tools that are valid and reliable across various contexts in South Africa. These tools need to account for several factors, such as:

- **Cultural fairness:** Assessments should account for cultural, linguistic, and social differences that may influence a child's understanding and decision-making. Engaging experts from diverse cultural backgrounds during the development phase can help ensure these tools are inclusive.
- **Developmental Considerations:** Age-appropriate guidelines that recognise different emotional, psychological, and cognitive development stages in children are necessary. This would ensure that the tools assess maturity and mental capacity according to a child's developmental stage.
- **Validity and Reliability:** These tools must be validated across different population groups in South Africa to ensure that they consistently and accurately measure maturity and capacity. Pilot testing the tools in diverse communities could help establish their reliability and effectiveness in real-world situations.

- **Adaptability:** The assessment tools should be flexible and adaptable to the unique situations of each child. This may involve providing different versions of the tools in multiple languages or incorporating visual aids relevant to children from different backgrounds.
- **Collaborative Development**: The creation of these tools should involve multi-disciplinary teams of paediatricians, psychiatrists, and psychologists, for expert knowledge on child development as well as cultural and linguistic experts to ensure that the tools are respectful and applicable across cultural lines.
- **Ethical Considerations:** Ethical principles such as autonomy and the best interests of the child should underpin the development of these tools, ensuring that assessments do not unintentionally disadvantage or discriminate against certain children based on cultural or socio-economic factors.

Once developed, these tools should be incorporated into the training of health professionals. Regular updates and reviews, informed by new research and cultural shifts, will help maintain their relevance and effectiveness. By establishing these standardised, culturally sensitive assessment tools, South Africa can significantly improve the consistency and effectiveness of Section 129(2) implementation, ensuring that children's rights to autonomy are respected in healthcare decisions.

d. Training and awareness among health professionals.

The lack of awareness and understanding of the specific requirements of the law regarding consent for children presents another serious challenge to the effective implementation of Section 129(2). This knowledge gap can lead to inconsistent

application, potentially risking children's rights to autonomy and healthcare. A comprehensive educational program should be developed and delivered to all health professionals, including doctors and nurses in primary healthcare settings to address this issue. The training should focus on:

- **Understanding Section 129(2):** Clear explanations of the law, including when it applies, who is affected, and what is required of health professionals.
- **Consent requirements for children:** Emphasising how consent differs for children and adults, including legal and ethical considerations.
- **Assessing maturity and mental capacity:** Providing tools and techniques for assessing whether a child has the maturity and mental capacity to provide informed consent once clear guidelines are developed.
- **Legal implications and accountability:** Providing information on the legal consequences of not properly assessing a child's capacity to consent and how to protect both the patient and the practitioner.

By educating all health professionals, the goal is to ensure that they are not only aware of Section 129(2) but are also equipped to apply it consistently and fairly, safeguarding the rights and well-being of children in healthcare settings.

e. Guidelines on assessing maturity and mental capacity.

The implementation of Section 129(2) is encountering significant challenges, primarily due to the absence of clear guidelines for assessing children's maturity and mental capacity. Health professionals grapple with this legal requirement without a standardised framework, leading to inconsistencies and potential legal and ethical risks. To tackle this

issue, there is an urgent need for the development of comprehensive guidelines. Considering our multilingual and multicultural context in South Africa, these guidelines should establish clear criteria for evaluating children's maturity and mental capacity.

The next step would be to assemble a multidisciplinary team of experts, including paediatricians and psychiatrists to provide insights on medical and developmental considerations, clinical and educational psychologists to offer expertise on cognitive and emotional maturity, ethicists to ensure adherence to ethical principles, and legal professionals to ensure alignment with existing laws and protection for both practitioners and patients. This team could then draft, refine, and implement the guidelines, creating a structured process for health professionals to follow when assessing children under Section 129(2). It's also essential to plan regular reviews of these guidelines, incorporating feedback from practitioners in the field and adapting to new research or legal updates."

REFERENCES

African Charter on the Rights and Welfare of the Child (ACRWC). 1990. Available at: https://au.int/sites/default/files/treaties/36804-treaty-african_charter_on_rights_welfare_of_the_child.pdf. Accessed: 17/05/2024.

Akpa-Inyang, F. & Chima, S.C. 2021. South African traditional values and beliefs regarding informed consent and limitations of the principle of respect for autonomy in African communities: a cross-cultural qualitative study. *BMC Medical Ethics, 22, 111, 1-17.* Available at: https://doi.org/10.1186/s12910-021-00678-4. Accessed: 20/11/2023.

Amer, A.B. 2019. Understanding the Ethical Theories in Medical Practice. *Open Journal of Nursing, 9, 188-193.* Available at: http://www.scirp.org/journal/ojn. Accessed: 09/05/2024.

American Psychological Association(APA) Task Force on Psychological Assessment and Evaluation Guidelines. 2020. APA Guidelines for Psychological Assessment and Evaluation. Available at: https://www.apa.org/about/policy/guidelines-psychological-assessment-evaluation.pdf. Accessed/ 05/07/2024.

Amod, Z. & Seabi, J. 2013. Dynamic assessment in South Africa, in Laher, S & Cockcroft, K (ed.) *Psychological assessment in South Africa, research, and applications.* Johannesburg: Wits University Press, p. 120-136.

Aschieri, F. 2012. Epistemological and ethical challenges in standardised testing and collaborative assessment. *Journal of Humanistic Psychology, 52(3), 350–368.* Available at: https://doi.org/10.1177/0022167811422946. Accessed: 23/05/2023.

Baines, P.B. 2015. Making Medical Decisions for Children: Ethics. Doctoral thesis. Birmingham University.

Bango-Rili, N. 2021. Consent to medical treatment: To what extent does the post-1994 South African legal framework on consent protect patients: A critical review. Master's Thesis: University of KwaZulu Natal. Available at: https://researchspace.ukzn.ac.za/handle/10413/20914. Accessed: 24/06/2023.

Barbie, E.R. & Mouton, J. 2007. *The practice of social research (11th Ed).* Cape Town: Oxford University Press.

Beauchamp, T.L. and Childress, J.F. 2009. *Principles of Biomedical Ethics (6th Ed).* Oxford: Oxford University Press.

Berens, C.K. & Scott, Y.H.K. 2022. Should Assessments of Decision-Making Capacity Be Risk-Sensitive? A Systematic Review. *Frontiers in psychology,13: 897144.* Available at: https://pubmed.ncbi.nlm.nih.gov/35846634/. Accessed: 18/09/2023.

Berk, L. E. 2007. *Development through lifespan.* Boston: Pearson.

Berg, S. 2022. “What doctors wish patients knew about scope of practice”. *American Medical Association (AMA) News Wire,* 19 August. Available at: https://www.ama-assn.org/practice-management/scope-practice/what-doctors-wish-patients-knew-about-scope-practice. Accessed: 18/09/2023.

Bester, M., Havenga, Y. & Ligthelm, Z. 2018. Practices employed by South African healthcare providers to obtain consent for treatment from children. *Nursing Ethics, 25(5) 640–652.* Available at: https://journals.sagepub.com/doi/abs/10.1177/0969733016660878. Accessed: 03/03/2023.

Bird, S. 2011. Consent to medical treatment: the mature minor. *Australian Family Physician, 40, (3), 159-160.*

Binford, W. 2015. The Constitutionalisation of Children’s Rights in South Africa. *New York Law School Review 60, (2).* Available at: *https://digitalcommons.nyls.edu/nyls_law_review?utm_source=digitalcommons.nyls.edu%2Fnyls_law_review%2Fvol60%2Fiss2%2F3&utm_medium=PDF&utm_campaign=PDFCoverPages*. Accessed: 03/03/2024.

Buchanan, A. & Brock, D. 1990. *Deciding for others: Ethics of surrogate decision making.* Cambridge: Cambridge University Press.

"Maturity" *Cambridge Dictionary.com*. 2024. https://dictionary.cambridge.org/dictionary/english/maturity. (25 September 2024).

Chima, S.C. 2013. Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study. *BMC Medical Ethics, 14 (1). 1-17.* Available at: http://www.biomedcentral.com/1472-6939/14/S1/S3. Accessed: 04/03/2023.

Chima, S.C. 2020. Informed consent in South Africa: a legal, ethical, and cross-cultural perspective, in Vansweevelt T, Glover-Thomas N, editors. Informed consent and health: a global analysis. Cheltenham: Edward Elgar Publishing, p. 183–214. Available at: https://doi.org/10.4337/9781788973427.00016. Accessed: 11/23/2023.

Chukwuneke, F.N., Ezenwugo, A.C. 2022. Deontology vs. utilitarianism: Understanding the basis for the moral theories in medicine. *International Journal of Medicine and Health Development, 27:19-23.*

Cohen, R. J., & Swerdlik, M. E. 2005. *Psychological testing and assessment: An introduction to tests and measurement* (6th ed). New York: McGraw-Hill.

Crossley, N. 2020. Conceptualising Consistency: Coherence, Principles, and the Practice of Human Protection. *Global responsibility to protect, 12, 440-463*.

Culver, C. K. 2004. Varieties of Vagueness. *University of Toronto Law Journal, 54, (1), 109-127.* Available at: *https://doi.org/10.1353/tlj.2004.0002.* Accessed: 03/31/2024.

Daly, A. 2020. Assessing Children's Capacity: Reconceptualising our Understanding through the UN Convention on the Rights of the Child. *International journal of children's rights, 28, 471-499.*

Danielson, M., Månsdotter, A., Fransson, E., Dalsgaard, S. & Larsson, J.O. 2019. Clinicians' attitudes toward standardised assessment and diagnosis within child and adolescent psychiatry. *Child and Adolescent Psychiatry and Mental Health, 13 (9).*

Donen, M. 2020. The rule of law in South Africa should not be arbitrary. *IOL, 29 June.* Available at: https://www.iol.co.za/capetimes/opinion/rule-of-law-in-south-africa-should-not-be-arbitrary-50096442. Accessed: 23/04/2023.

Driver, J. 2009. Normative Ethics in Jackson, F. & Smith, M. (Eds) *The Oxford Handbook of Contemporary Philosophy, p. 31–62.* Available at: *https://doi.org/10.1093/oxfordhb/9780199234769.001.0001.* Accessed: 13/05/2024.

Driver, J. 2022. History of utilitarianism in Zalta, E.N. & Nodelman, U. *The Stanford Encyclopedia of Philosophy.* Available at: https://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=utilitarianism-history. Accessed: 02/26/2024.

Du Preez, H., & De Klerk, W. 2019. A psycho-philosophical view on the 'conceptualisation' of psychological measure development. *SA Journal of Industrial Psychology, 45, a1593, 1-10.* Available at: https://www.scielo.org.za/pdf/sajip/v45n1/19.pdf. Accessed: 07/23/2023.

Du Preez, W.R. 2011. The Medical Treatment of Children and the Children's Act 38 of 2005. Master Thesis. University of Pretoria: Pretoria.

Du Plessis, L.M. 2002. Reinterpretation of statutes. Butterworths: LexisNexis.

Ferlito, B. A. & Dhai, A. 2018. The Life Esidimeni tragedy: Some ethical transgressions. *South African Medical Journal, 108(3):157.* Available at: https://www.scielo.org.za/pdf/samj/v108n3/07.pdf. Accessed: 12/08/2024.

Fisher, C., Cusack, G., Cox, K., Feigenbaum, K. & Wallen, R.G. 2016. Developing Competency to Sustain Evidence-Based Practice. *The Journal of Nursing Administration, 46, (11), pp. 581-585.* Available at: https://www.jstor.org/stable/10.2307/26813759. Accessed: 12/08/2024.

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,17(66)*. Available at: https://doi.org/10.1186/s12910-016-0150-0 Accessed: 13/05/2024.

Godwin, S. 2020. Children's Capacities and Paternalism. *The Journal of Ethics, 24, 307–331. Available at:* https://doi.org/10.1007/s10892-020-09327-1. Accessed 11/07/2024.

Govender, S. 2023. One in 10 doctors under investigation by HPCSA contemplated suicide: survey. *Timeslive,* 16 July. Available at: https://www.timeslive.co.za/news/south-africa/2023-07-06-one-in-10-doctors-under-investigation-by-hpcsa-contemplated-suicide-survey/.

Havenga, Y. & Temane, M.A. 2016. Consent by children: considerations when assessing maturity and mental capacity. *South African Family Practice, 58 (1), 43-46.* Available at: https://www.tandfonline.com/action/showCitFormats?doi=10.1080%2F20786190.2014.977058. Accessed: 04/03/2023.

Health Professions Council of South Africa (HPCSA). 2021. Guidelines for good practice in the healthcare professions seeking patients' informed consent: The ethical considerations. Booklet 4. Available At: https://www.hpcsa.co.za/Uploads/professional_practice/ethics/Booklet_4_Informed_Consent_vDec_2021.pdf. Accessed: 04/02/2023.

Health Professions Council of South Africa (HPCSA). 2019. Framework for Education, Training, Registration and Scope for Psychometry. Available At:

https://www.hpcsa.co.za/Content/upload/psb/guidelines/Form_94_Psychometry.pdf. Accessed: 04/09/2024.

Health Professions Council of South Africa (HPCSA). 2021. Continuing Professional Development. Available At: https://www.hpcsa.co.za/Content/upload/professional_practice/cpd/CPD_Guidelines_Nov_2021.pdf. Accessed: 04/09/2024.

Hein, I., M., Troost, P.W., Broersma, A., de Vries, M.C., Daams, J.G. & Lindauer, J.L.R. 2015. Why is it hard to make progress in assessing children's decision-making competence? *BMC Medical Ethics, 16:1.* Available at: http://www.biomedcentral.com/1472-6939/16/1. Accessed: 13/05/2024.

Herring, J. 2016. *Vulnerable adults, and the law*. Oxford: Oxford University Press.

Himonga, C & Cooke, A. 2007. A child autonomy with special reference to reproductive medical decision-making in South African law: Mere illusion or real autonomy. *International journal of children's rights, 15. 323-363.* Available at: https://brill.com/view/journals/chil/15/3-4/article-p323_1.xml?language=en. Accessed: 02/07/2023.

Hunter, M.B., Ogunlayi, F., Middleton, J. & Squires, N. 2023. Strengthening capacity through competency-based education and training to deliver the essential public health

functions: reflection on the roadmap to build public health workforce. *BMJ Global Health, 8 (3),1-5* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10008161/pdf/bmjgh-2022-011310.pdf. Accessed: 11/07/2023.

Institute of Medicine (IOM). 2011. *Clinical Practice Guidelines We Can Trust (Consensus Report).* Washington DC: National Academies Press.

Jaars, C. B. 2021. Constitutional interpretation of statutes in the Republic of South Africa. Available at: https://www.researchgate.net/publication/348558945. Accessed: 23/04/2024.

Jacklin, L. & Cockcroft, K. 2013. The Griffiths Mental Developmental Scales: an overview and a consideration of their relevance for South Africa in Laher, S & Cockcroft, K (ed.) *Psychological assessment in South Africa, research, and applications.* Johannesburg: Wits University Press, p. 169-185.

Jeremic, V., Sénécal, K., Borry, P., Chokoshvili, D. & Vears, D.F. 2016. Participation of Children in Medical Decision-making: Challenges and Potential Solutions. *Journal of Bioethical Inquiry, 1-10, DOI 10.1007/s11673-016-9747-8.* Available at: https://www.researchgate.net/publication/309046044. Accessed 11/02/2024.

Kilkelly, U. & Liefaard, T. 2019. Legal implementation of the UNCRC: lessons to be learned from the constitutional experience of South Africa. *De Jure Law Journal, 521-539.* Available at: http://dx.doi.org/10.17159/2225-7160/2019/v52a30. Accessed:

Kilbride, K. M. & Joffe, S. 2018. The New Age of Patient Autonomy: Implications for the Patient-Physician Relationship. *JAMA, 320(19), 1973–1974.* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6988779/pdf/nihms-1067423.pdf

Koocher, G. P. & Keith-Spiegel, P. C. 1990. *Children, Ethics, and the Law: Professional Issues and Cases.* Lincoln, Nebraska: University of Nebraska Press.

Kruger, H. 2018. The Protection of Children's Right to Self-Determination in South African Law with Specific Reference to Medical Treatment and Operations. *PER / PELJ(21)* - DOI http://dx.doi.org/10.17159/1727- 3781/2018/v21i0a4609

Laher, S & Cockcroft, K. 2013. Current and future trends in psychological assessment in South Africa: challenges and opportunities, in Laher, S & Cockcroft, K (ed.) Psychological assessment in South Africa, research, and applications. Johannesburg: Wits University Press, p. 535-552.

Laher, S., Serpell, R., Ntinda, K. & Chireshe, R. 2022. “Psychological Assessment in Southern Africa” in Laher, S. (ed) *International histories of psychological assessment.* Cambridge: Cambridge University Press, pp. 21-46.

Legal Information Institute. 2021. Ambiguity. Available at: https://www.law.cornell.edu/wex/ambiguity. Accessed: 25/09/2024.

Le Grange, L. 2019. A comment on critiques of the article Age- and Education-related Effects on Cognitive Functioning in Colored South African Women. *South African Journal of Higher Education, 33 (4), 9-19.* Available at: http://dx.doi.org/10.20853/33-4-3715. Accessed: 23/05/2023.

Le Roux, W. 2019. "Editorial: Special Edition-Legal Interpretation after Endumeni: Clarification, Contestation, Application. PER /PELJ, 22. Available at: http://dx.doi.org/10.17159/1727-3781/2019/v22i0a7510. Accessed: 23/08/2023.

Leslie, K., Moore, J., Robertson, C., Bilton, D., Hirschkorn, K., Langelier, M.H., Bourgeault, I.L. 2021. Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. *Human Resource Health 19(15): 1-12*. Available at: https://doi.org/10.1186/s12960-020-00550-3. Accessed: 29/06/2023.

Lynøe, N., Engström, I. & Juth, N. 2021. How to reveal disguised paternalism: version 2.0. *BMC Medical Ethics, 22, 170, 1-8.* Available at: https://doi.org/10.1186/s12910-021-00739-8. Accessed: 29/06/2023.

Majuta, M. J., Tsoeu, M. & Kgalema, M. 2015. The Judicial Role in the Legislative Lawmaking Process in Africa: The South African Case. *The African Review: A Journal of African Politics, Development and International Affairs, 42, (1), 1-28.* Available at: https://www.jstor.org/stable/45341693. Accessed: 29/06/2023.

Malherbe, J. 2013. Counting the cost: The consequences of increased medical malpractice litigation in South Africa. *South African Medical Journal;103(2):83-84. DOI:10.7196/SAMJ.6457.* Available at: http://www.scielo.org.za/pdf/samj/v103n2/15.pdf Accessed: 01/04/2024.

Marchant, G. J. 2004. What is at Stake with High Stakes Testing? A Discussion of Issues and Research. *Ohio Journal of Science, 104, (2).* Available at: *http://hdl.handle.net/1811/25124*. Accessed: 23/06/2023.

McConnachie, C. Skelton, A. & McConnachie, C. 2017. The constitution and the right to a basic education. *Section 27.* Available at: https://section27.org.za/wp-content/uploads/2017/02/Chapter-1.pdf Accessed: 01/04/2024.

Medical Brief. 2021. Doctors in a new turf war with pharmacists over 'unlawful and unfair' competition. *Juta Medical Brief, September 15.* Available at: https://www.medicalbrief.co.za/doctors-in-new-turf-war-with-pharmacists-over-unlawful-and-unfair-competition/. Accessed:06/07/2023.

"Ambiguity" *Merriam-Webster.com*. 2024. https://www.merriam-webster.com/dictionary/ambiguity. (10 September 2024).

"Capacity" *Merriam-Webster.com.* 2024. https://www.merriam-webster.com/dictionary/capacity. (10 September 2024).

Misselbrook, D. 2015. Virtue ethics – an old answer to a new dilemma? Part 1. Problems with contemporary medical ethics. Journal of the Royal Society of Medicine, 108(2) 53–56. DOI: 10.1177/0141076814563367. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4344448/pdf/10.1177_0141076814563367.pdf. Accessed: 07/05/2024.

Moosa, F. 2018. Understanding the "Spirit, Purport and Objects" of South Africa's Bill of Rights. Journal of Forensic Legal & Investigative Sciences, 22(4), http://dx.doi.org/10.24966/FLIS-733X/100022

Moye, J. & Marson, D. 2007. Assessment of decision-making capacity in older adults: an emerging area of practice and research. *The Journal of Gerontology Series B Psychological Sciences and Social Sciences, 62B (1), 3-11.* Available at: https://www.researchgate.net/publication/6519337. Accessed: 30/08/2023.

Moritz, D. 2023. Children's developmental (IM)maturity: Aligning conflicting decisional capacity assessment approaches in Australia. *Laws, 12 (10). 1-20.* Available at: https://doi.org/10.3390/laws1200110010. Accessed 24/02/2023.

Motloba, D. & Makwakwa, N.L. 2018. Respecting Autonomy (Part 2). *South African Dental Journal, 73, 7,460 – 462.* http://dx.doi.org/10.17159/2519-0105/2018/v73no7a7. Available at: https://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0011-51620180007000009. Accessed: 10/05/2024.

Mulder, M. 2014. Conceptions of Professional Competence. In: S. Billett, C. Harteis, H. Gruber (Eds), International Handbook of Research in Professional and Practice-based Learning. Dordrecht: Springer. pp. 107-137.

Nguse, S. & Wasenaar, D. 2021. Mental health and COVID-19 in South Africa. *South African Journal of Psychology, 51(2) 304–313.* Available at: https://doi.org/10.1177%2F00812463211001543. Accessed: 23/08/2023.

O'Neill, O. 2002. Autonomy and Trust in Bioethics. Cambridge: Cambridge University Press.

Paron, K. 2020. The Child's Autonomy in Decision-making on Medical Treatment: Theoretical Considerations. Juridica International, 29, 124-132. Available at: https://doi.org/10.12697/JI.2020.29.11. Accessed: 13/05/2024.

Paterson, H. & Uys, K. 2005. Critical issues in psychological test use in the South African workplace. *SA Journal of Industrial Psychology, 31 (3), 12-22.* Available At: https://pdfs.semanticscholar.org/db87/e1ea847667dc1e620eaeba3641b46dac0871.pdf. Accessed: Accessed: 08/08/2023.

Pereira, V.C., Silva, S.N., Carvalho, K.S.V, Zanghelini, F. & Barreto, O.M.J. 2022. Strategies for the implementation of clinical practice guidelines in public health: an overview of systematic reviews. *Health Research Policy and Systems, (20)13,1-21.* Available at: https://doi.org/10.1186/s12961-022-00815-4. Accessed: 08/08/2023.

Perumalsamy, K. 2019. The Life and Times of Textualism in South Africa. PER / PELJ (22) - DOI http://dx.doi.org/10.17159/1727-3781/2019/v22i0a7418.

Pillay, A.L. & Willows, C. 2015. Assessing the criminal capacity of children: a challenge to the capacity of mental health professionals. *Journal of Child & Adolescent Mental Health, 27:2, 91-101*, DOI: 10.2989/17280583.2015.1040412.

Pillay, A.L. & Singh, J.A. 2017. 'Mental capacity', 'sufficient maturity', and 'capable of understanding' in relation to children: how should health professionals interpret these terms? Available at: http://dx.doi.org/10.1177/0081246317747148. Accessed: 12/04/2024.

Price, P.C., Crump, M.J.C., Jhangian, I.R., Chiang, I.A., & Leighton, D.C. 2017. *Research methods in psychology.* Fresno: California State University.

Prinsen, L. 2023. The leading causes of medicolegal claims and possible solutions. South African Medical Journal, 113(4), 1140-1142. Available at: https://doi.org/10.7196/SAMJ.2023.v113i4.134. Accessed: 09/07/2024.

Proudlock, P. & Jamieson, L. 2010. The Children's Act, providing a strong foundation for caring for vulnerable children. *Child and Youth Care Work, 28, (2), 31-35.* Available at: https://ci.uct.ac.za/sites/default/files/content_migration/health_uct_ac_za/533/files/childrens_act_march_april2010.pdf. Accessed: 20/08/2023.

Psychological Society of South Africa (PSYSSA). 2007. South African professional conduct guidelines in psychology. Available at: https://www.psyssa.com/wp-content/uploads/2016/12/SOUTH-AFRICAN-PROFESSIONAL-CONDUCT-GUIDELINES-IN-PSYCHOLOGY-2007-PsySSA_updated. Accessed: 20/08/2023.

Ramaswamy, K. 2018. The Right to Education: An Analysis through the Lens of the Deontological Method of Immanuel Kant. *Northwestern Journal of Human Rights, 16, 48-64.* Available at: *https://scholarlycommons.law.northwestern.edu/njihr/vol16/iss1/3. Accessed: 23/05/2023.*

Ruhe K. M., Wangmo T., Badarau D.O., Elger, B.S., Niggli, F. 2015. Decision-making capacity of children and adolescents--suggestions for advancing the concept's implementation in pediatric healthcare. *European Journal of Pediatrics;174(6):775-82.* Available at: https://doi.org/10.1007/s00431-014-2462-8. Accessed: 23/05/2023.

Schapiro, T. 2003. Childhood and personhood. *Arizona Law Review, 45, 575-594*. Available at: https://www.arizonalawreview.org/pdf/45-3/45arizlrev575.pdf. Accessed: 23/05/2023.

Schoeman, M.I. 2006. Determining the age of criminal capacity, acting in the best interest of the children in conflict with the law. *SA Crime Quarterly, 57, 35-42.* Available at: https://doi.org/10.17159/2413-3108/2016/i57a39. Accessed: 01/04/2024.

September, R. 2014. A new Children's Act for South Africa: making it work For children and families. *Social Work/Maatskaplike Werk, 44(2).* Available at: https://doi.org/10.15270/44-2-247. Accessed: 01/04/2024.

Setshedi, M. J. 2008. Investigating the use of psychological Assessment in South African schools. Master's thesis. University of Witwatersrand: Johannesburg.

Society for Industrial and Organisational Psychology of South Africa (SIOPSA). 2005. Guidelines for validation and use of psychological procedures in the workplace. Available

at: https://www.siopsa.org.za/wp-content/uploads/2021/11/Guidelines-for-the-Validation-and-Use-of-Assessment-Procedures-for-the-Workplace-PAI.pdf. Accessed: 10/05/2024.

Skelton, A. 2019. Too much of a good thing? Best interests of the child in South African jurisprudence. 2019 De Jure Law Journal 557-579, Available at: http://dx.doi.org/10.17159/2225-7160/2019/v52a32 . Accessed: 29/11/2023.

Slabbert, M. & Labuschaigne, M. 2022. Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance. South African Journal of Bioethics Law;15(1):31-35. Available at: https://doi.org/10.7196/SAJBL.2022.v15i1.786. Accessed: 20/01/2024.

South African College of Psychology (SACAP). The shocking state of mental health in South Africa in 2019. Available at: https://www.sacap.edu.za/blog/management-leadership/mental-health-south-africa. Accessed: 10/05/2024.

South African Medical Association (SAMA). Broadened scope of pharmacists unlawful, unfair, and not in patients' best interests | SAMA. Available at: https://www.samedical.org/cmsuploader/viewArticle/1860. Accessed 30/06/2023.

Sugarman, J. & Sulmasy, D. 2010. *Methods in medical ethics, 2nd edition*. Georgetown: Georgetown University Press.

Suzuki, L. A., & Ponterotto, J. G. 2008. *Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications, 2nd edition*. Hoboken: Jossey-Bass.

Sorsdahl, K., Petersen, I., Myers, B., Zingela, Z., Lund, C. & van der Westhuizen, C. 2023. A reflection of the current status of the mental healthcare system in South Africa. *SSM-Mental health, (4), 3-9.* Available at: https://doi.org/10.1016/j.ssmmh.2023.100247. Accessed: 09/05/2024.

Stojkovic, V.J., Vears, D.F., Matejic, B., Gazibara, T., Turza, K. & Cvjetkovic, S. 2022. Adolescents' Capacity to Make Decisions in Healthcare: Perspectives of Serbian Primary Care Physicians. *Journal of Child and Family Studies, 31, 3268–3280.* Available at: https://doi.org/10.1007/s10826-022-02365-3. Accessed: 09/05/2024.

Tan, O.A.J & Fegert, M.J. 2004. Capacity and Competence in Child and Adolescent Psychiatry. *Health Care Analysis, 12 (4). 285-294.* Available at: https://link.springer.com/article/10.1007/s10728-004-6636-9. Accessed 24/02/2023.

Teichmann, C. 2022. *Mental health for all is not a reality in South Africa, Mail @ Guardian, October 10,* https://mg.co.za/thought-leader/opinion/2022-10-10-mental-health-for-all-is-not-a-reality-in-south-africa/. Accessed? 10/04/2024.

Theron, L. C. 2013. Assessing school readiness using the Junior South African Individual Scales: a pathway to resilience, in Laher, S & Cockcroft, K (ed.) Psychological

assessment in South Africa, research, and applications. Johannesburg: Wits University Press, p. 60-73.

Thomas, R. 2007. Where to from *Castell v de Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure. *South African Law Journal, 124(1), 188-215.*
Available at: https://open.uct.ac.za/handle/11427/16509. Accessed: 17/09/2023.

Thompson, H. 2020. Children's autonomy in medical decision-making. *Honor Scholar Theses, 164. Available at: https://scholarship.depauw.edu/studentresearch/164.* Accessed: 20/03/2023.

Timmer, D. 2023. On the Idea of Degrees of Moral Status. *The Journal of Value Inquiry, 1-19.* Available at: https://doi.org/10.1007/s10790-023-09970-5. Accessed: 02/06/2024.

Tseng, P.-E.; Wang, Y.-H. 2021. Deontological or Utilitarian? An Eternal Ethical Dilemma in Outbreak. International Journal of Environmental Research and Public Health, 18, 8565.Available at: https://doi.org/10.3390/ijerph18168565. Accessed: 20/05/2024.

United Nations Children's Fund (UNICEF) South African and South African Human Rights Commission. 2011. South Africa's children: a review of equity and child's rights. Available at: https://www.unicef.org/southafrica/media/1166/file/ZAF-south-africas-children-2011_1.pdf. Accessed: 25/08/2024.

United Nations Convention on the Rights of Children (UNCRC). 1990. Available on https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child Accessed: 25/02/2023.

United Nations (UN). 1948. Universal Declaration of Human Rights. Available at: https://www.ohchr.org/sites/default/files/UDHR/Documents/UDHR_Translations/eng.pdf. Accessed: 23/04/2023.

van der Merwe, I. de Klerk, W. & Erasmus, P. 2020. Intelligence Instruments Applied to South African School Learners: A Critical Review. *Front. Psychol, 13,853239*. Available at: https://doi.org/10.3389/fpsyg.2022.853239. Accessed: 20/05/2023.

Van der Westhuizen, C. 2018. Medical treatment v surgery: where does medical treatment end and surgery begin in terms of section 129 of the Children's Act? *Obiter, 39 (3), 791-802.* Available at: *https://journals.co.za/doi/epdf/10.10520/EJC-1487a5f224.* Accessed: 12/06/2024.

van Heerden, J., Delport, R. & Kruger, M. 2020. *Children's ability to consent to medical management in South Africa. South African Journal of Child Health, 14(1):25-29. Available at: https://doi.org/10.7196/SAJCH.2020.v14.i1.1621. Accessed: 29/06/2023.*

Varkey, B. 2021. Principles of Clinical Ethics and Their Application to Practice. *Medical principles and practice, 30:17–28. Available at: https://www.karger.com/Journal/Home/224259. Accessed? 18/03/2023.*

Wall, J. 2008. Human Rights in Light of Childhood. *International Journal of Children's Rights 16, 523–543.*

Wallis, M. 2019. Interpretation Before and After Natal Joint Municipal Pension Fund v Endumeni Municipality 2012 4 SA 593 (SCA). *PER / PELJ (22).* Available at: http://dx.doi.org/10.17159/1727-3781/2019/v22i0a7416. Accessed: 13/05/2024.

Woolf, H.S., Grol, R., Hutchinson, A., Eccles, M. & Grimshaw, J. 1999. Clinical guidelines: Potential benefits, limitations, and harms of clinical guidelines. *BMJ, 318, 527-530.* Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1114973/pdf/527.pdf. Accessed: 05/07/2024.

Legislations

Children's Act 38 of 2005.

Child Care Act 74 of 1983.

Child Justice Act 75 of 2008.

Constitution of the Republic of South Africa, 1996.

Employment Equity Act 55 of 1998.

Health Professions Act 56 of 1974.

National Health Act 61 of 2003.

Case law

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

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

Coopers & Lybrand v Bryant 1995 (3) SA 761 (A).

Fraser v Children's Court, Pretoria North, and others 1997 (2) SA 261 (CC).

Gillick v. West Norfolk and Wisbech Area Health Authority 1986 AC 112.

Jaga v Dönges 1950 (4) SA 653 (A).

Minister of Welfare and Population Development v Fitzpatrick and Others 2000 (3) SA 422 (CC).

Natal Joint Municipal Pension Fund v Endumeni Municipality 2012 (4) SA 593 (SCA).

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

S v Williams and Others 1995 (3) SA 632 (CC).