Adolescent self-consent to medical interventions in South Africa

A E Strode,[1,2] PhD; **Z Essack**,[1,2,3] PhD; **C M Slack**,[1,4] PhD

[1] *School of Law, University of KwaZulu-Natal, Pietermaritzburg, South Africa*
[2] *South African Research Ethics Training Initiative (SARETI), University of KwaZulu-Natal, Pietermaritzburg, South Africa*
[3] *Centre for Community-Based Research, Human Sciences Research Council, Pietermaritzburg, South Africa,*
[4] *HIV/AIDS Vaccines Ethics Group, School of Applied Human Sciences, University of KwaZulu-Natal, South Africa*

Corresponding author: *A E Strode (strodea@ukzn.ac.za)*

South African law provides that children under 18 years old can self-consent to medical treatments and terminations of pregnancy. An article published by van Heerden *et al.* in the *South African Journal of Child Health* in 2020 found that children 12 years and older were able to give informed consent to medical procedures because they were able to make a treatment choice, comprehend information, weigh options and provide reasons for their decision. However, only children older than 14 years possessed actual understanding of more abstract concepts. This paper considers whether the law is consistent with empirical data on child capacity. It does so by examining the evolution of laws regarding child capacity, interrogating current legal standards on capacity and ultimately evaluating whether the law reflects current empirical knowledge. We conclude that the law on medical treatment is not in conflict with the findings of van Heerden *et al.* However, there is less synergy between law and empirical data regarding terminations of pregnancy for children under 14 years old. Parliament placed an emphasis on access to health services and did not want age or parental consent to act as a barrier to adolescents getting medical assistance; however, data show that children younger than 14 years old struggle with more complex and abstract medical choices. We suggest that the recommendations in the Choice Act for counselling in terminations of pregnancy by children under the age of 14 years need to be more fully operationalised through the issuing of regulations or a national policy.
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An article published in the *South African Journal of Child Health* in 2020 used empirical methods to explore whether children were able to make treatment choices. .[1] This was significant as South African (SA) law provides that under 18-year-olds can self-consent to medical treatment and terminations of pregnancy.[2-4] The researchers found that children aged 12 years and older were capable of giving informed consent to medical procedures as they were able to make a treatment choice, understand information, weigh options and provide reasons for their decision.[1] However, only children older than 14 years understood more abstract concepts; therefore, the reasoning ability of adolescents under 14 years old was not identical to that of adults.[1]

In the light of this finding, Van Heerden *et al.*[1] posed a pertinent question – is the law regarding when adolescents may self-consent to medical treatment or abortions in sync with current evidence regarding their capacity for medical decision-making? We respond to this question in the present paper by reflecting on the evolution of laws regarding the decision-making capacity of children, interrogating current legal standards on capacity and evaluating whether the law reflects current empirical knowledge.

Legal standards for adolescent healthcare choices

Legally, to make a healthcare choice a person must have the capacity to understand the risks, weigh options, make a choice and provide reasons for their decision.[1,5-7] Capacity is a person's ability to perform a juristic act (any action which has legal consequences).[8] SA courts have held that capacity has two elements: (*i*) the ability to understand, intellectually and emotionally, the nature and consequences of the act being undertaken; and (*ii*) the ability to exercise judgement, i.e. make a decision.[5]

Traditionally, the law has limited the capacity of children to make decisions with legal consequences through the concept of minority.[8] This was viewed as a means to protect minors from the consequences of decisions they make before adulthood.[8] However, following the adoption of the Convention on the Rights of the Child (CRC) in 1989,[9] there has been a gradual move towards balancing child protection with a recognition of their emerging autonomy.[10] Article 12 of the CRC provides that children have a right to take part in decisions that affect them in accordance with their stage of development.[9] Accordingly, children are entitled but not duty-bound to take part in decision-making with the possibility of influencing the outcome.[11]

This recognition of children's evolving capacity has led to law reform relating to consent to medical interventions.[12] Previously, the common law required parental or guardianship consent for all medical treatment of children.[5,13] Later, the 1984 Child Care Act[14] provided that children could consent independently to medical treatment from the age of 14.[12,14] Currently, the Children's Act provides children aged 12 years can consent independently to medical treatment if they have 'sufficient maturity' and 'mental capacity' to understand the 'benefits, risks, social and other implications of the treatment'.[2-4,15-17]

Regarding consent to terminations of pregnancy, parental consent was previously required for all terminations of pregnancy for pregnant minors.[18] Reform was introduced through the 1996 Choice on Termination of Pregnancy Act[19] which provides that a child may consent independently to an abortion. No age is specified in the Act; however, as a protective measure, the child must be advised to consult

others regarding the decision.[2-4,16,19] Nevertheless, she may not be denied access to a termination if she does not choose to consult with others.[19] Further, Section 4 of the Choice Act[19] places an obligation on the state to 'promote' counselling which is 'non-mandatory and non-directive' both before and after the termination to all children.

If we unpack the legal requirements for capacity, i.e. understanding and an ability to exercise one's judgement, there is some guidance in the legislation itself. Firstly, understanding requires the provision of information and an assessment of the information. The National Health Act[20] sets out what information should be provided to patients. This includes their health status, the spectrum of treatment options and the right to refuse treatment. The Children's Act is very similar, although it also requires children to be given information on the causes of their condition.[15] With a termination of pregnancy, the only information which must be provided is on the patient's rights within the Act.[19] In terms of assessing understanding, the National Health Act is silent but the Children's Act states a child must appreciate the 'benefits, risks, social and other implications of the treatment'.[15] There is no guidance on assessing understanding in the Choice of Termination on Pregnancy Act. Nevertheless, the provisions in the National Health Act would apply to terminations of pregnancy, so practitioners would be obliged to ensure information and understanding of a patient's health status (i.e. the pregnancy stage, etc), the benefits, risks and consequences (of the termination/continuing with the pregnancy), and their right to refuse treatment (i.e. they are not compelled to have a termination).[20] They would also have to be advised on their rights in terms of the Choice Act, i.e. rights to confidentiality, independent consent, to consult others, access to counselling and the circumstances in which a termination would be lawful.[19]

Secondly, regarding the ability to make a treatment choice, the Children's Act requires that the child be 12 years old and have 'sufficient maturity'.[15] The concept of maturity is used to reflect the child's stage of intellectual and emotional development, with a child becoming 'mature' at adulthood, i.e. 18 years old.[8] The complexity with the legal approach to maturity is that it is both a rigid and a flexible concept. It is rigid in the sense that it is linked to age (18 years) with the assumption that maturity exists at the specified age. It is also flexible as a child can be considered mature enough to consent to medical treatment if they have 'sufficient maturity', i.e. not full maturity, which they attain at 18 years, but enough to understand and make a treatment choice. Although the Choice Act[19] does not set an express capacity requirement, the Christian Lawyers Association case [5] clarified this apparent silence by stating that:

'Instead of using age as a measure of control or regulation, the legislature resorted/opted to use capacity to give informed consent as the yardstick. Where such capacity exists, the Act recognises it in spite of the youthfulness or age of the person. Where it does not exist, then no such recognition is given …. (Para 23).'

Specifically, if a pregnant minor does not have the capacity to consent to a termination, parental consent or consent from a legal guardian would be required. Likewise, if an adult lacks capacity, another legally authorised person would have to provide consent on their behalf.[20]

The Children's Act does not recommend any decisional support measures in relation to consent to medical treatment, but the Choice Act provides two: (*i*) the first concerns children specifically, requiring that the child be advised to consult others on the decision to terminate;[19] and (*ii*) the Choice Act requires access to counselling.[19] In this regard the state's duty is to 'promote' counselling but it is unclear exactly what this requires; is it to offer the counselling service or simply advise patients of the importance of counselling?

The van Heerden study

To determine whether children were able to give informed consent to medical treatment, van Heerden *et al.*[1] undertook an empirical study with 150 participants (125 children aged 10 to 17 years and 25 adults). Using an interactive methodology, they asked participants to make healthcare choices based on three storyboards involving diabetes, depression and epilepsy.[1]

The researchers found that all participants were able to make a healthcare choice.[1] Furthermore, 12- to 17-year-olds were able to demonstrate a level of understanding of the information provided, choose a treatment option and give reasons for their choice; these choices were similar to those of adults.[1] However, the findings showed that younger children (12- and 13-year-olds) differed significantly from adults in terms of their understanding of abstract concepts.[1] Children under 14 years old listed fewer factors that underpinned their decisions and they did not discuss abstract concepts as extensively as adults.[1] This is somewhat consistent with Piaget's theory of cognitive development which suggests that abstract reasoning develops in children after age 11 and reaches equilibrium at 14.[1,21]

Van Heerden *et al.*[1] concluded that 'basic choices regarding the administration of medicine and minor surgical interventions are within the decision-making abilities of younger children, but that psychiatric treatments and interventions with severe consequences are outside the scope of younger children's abilities'.

Discussion

Children are considered more vulnerable than adults owing to the way in which they make decisions. For example, they may be more susceptible to socially desirable decision-making in efforts to please parents, peers and medical staff.[1,22,23] Furthermore, it has been argued that their decision-making tends to be based on 'perceived hopes rather than facts'.[1]

Considering these complexities, legal protections are required. Children are rights-holders and this has changed the nature of legal protection. Previously, requiring parents to make decisions on behalf of children was seen as a means of protecting them from harm. However, in the post-CRC period the parent-child relationship has transformed.[9,10,24] Parents now have responsibilities and rights rather than parental authority.[15,25] The CRC has also changed the landscape regarding access to healthcare services, with SA taking a progressive approach to consent to various healthcare interventions.[2,3] This public policy choice was made in part on the recommendation of the South African Law Reform Commission after their review of the 1983 Child Care Act.[12,14] The Commission noted that the age of consent to medical treatment acted as an obstacle to children receiving healthcare services.[12] The new approach addresses this as it enables certain adolescents to make healthcare choices without the assistance of their parents before the age of 18.[2,3]

Nevertheless, the evolving capacity of adolescents and its application within the legal framework governing healthcare choices is complex. Although there are some guidelines, as described above, they are broad and require individualisation for each patient. In over-burdened and under-resourced healthcare settings they are difficult to operationalise. Using age as a proxy for the determination of capacity has been criticised for being an arbitrary approach.[2,12] However, it is useful as a general guide to assess maturity, particularly as there is no gold-standard test to determine capacity for decision-making in children.[1,26] There are also other practical operational difficulties, such as assessing capacity outside of an existing or established patient-provider relationship.[27] Furthermore, medical treatment varies in nature and level of risk – which impact on a child's capacity to act independently – making fixed approaches inappropriate.[27]

Van Heerden *et al.*[1] posed a key question: are these law reforms in line with empirical evidence? In this instance, empirical data seem consistent with the law relating to consent to medical treatment, as children aged 12 years and older must have understanding and be sufficiently mature. This dual requirement means that some children between 12 and 14 years (or older) making choices about more complex treatment options may not meet the standard of understanding required and therefore would not have the capacity to consent to the specific treatment. The consequences of treatment options with riskier interventions, which may be more abstract in nature, are particularly concerning, while children have demonstrated understanding for routine medical choices.[1]

Regarding termination of pregnancy, Planned Parenthood (an international non-governmental organisation) recommends the consideration of a number of factors including whether the person is ready to start a family, the impact this would have on her life goals, family and current life circumstances, whether she is able to make the choice without feeling any pressure and the nature of the support she would get for her final choice.[28] It appears that at least some of these factors require abstract thought and consideration of long-term consequences. This suggests that some younger adolescents would not meet the required capacity threshold for independent consent. Thus, consent to different forms of treatment should be treated differently, and there should be a case-by-case evaluation of each child's capacity. The data published by van Heerden *et al.*[1] suggest that the law does not provide adequate protection for under 14-year-olds requesting riskier or more invasive treatment or an abortion. This may mean that additional protection should be provided, e.g. with HIV testing adolescents are required to undergo counselling.[2,3,15] There is a clear need for further research into suitable decisional supports for younger adolescents (aged 12 and 13 years) making independent healthcare decisions.

Conclusion

We suggest that the law (as it stands) is not in conflict with van Heerden *et al.*'s findings.[1] There is synergy between the law and the way in which parliament has crafted consent to medical treatment. However, there is less synergy, as van Heerden *et al.*[1] themselves suggest, with regard to terminations of pregnancy for adolescents under the age of 14. It appears that, in both instances, parliament appropriately placed an emphasis on access to services and did not want age or parental consent to act as an obstacle to adolescents obtaining medical assistance.[12] Given concerns regarding the implications of data on under-14 year olds making more complex or abstract medical choices, we suggest that the recommendations in the Choice Act for counselling need to be more fully operationalised through the issuing of regulations or a national policy for terminations of pregnancy for children under the age of 14 years. Practitioners need to be aware that additional decisional support may be required. As suggested by van Heerden *et al.*,[1] this means that practitioners must make an individual capacity assessment in each case. Furthermore, additional research is required on both the nature of decisional support and how to operationalise these approaches.

Finally, and considering our recommendations, we suggest the following in applying the law:

- Focus on the choice – establish the nature of the information and understanding that would be required for the decision. Practitioners ought to be mindful that 12- to 14-year-olds will struggle to understand abstract concepts.
- Contextualise the child – consider their age, life circumstances and ability to weigh and balance various factors that will guide them to an appropriate decision.
- Identify and develop decisional supports for younger children – such as age-appropriate materials that set out the potential risks and benefits of the intervention in simple, non-technical language – ideally with input from affected stakeholders representing adolescents.
- Involve parents, guardians or caregivers when children do not have capacity or where the child wishes to involve them in decision-making.

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