*Review Paper*

# Evaluating the Legal and Ethical Dimensions of Consent in Children aged 12 years and over: A Comparative Analysis of Section 129(2) of the South African Children's Act through Kantian and Utilitarian Frameworks

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**ABSTRACT**

This article interrogates the ethical justifiability of Section 129(2) of the South African Children's Act 38 of 2005, which allows South African children aged 12 and older to consent to medical treatment if deemed sufficiently mature. The analysis is grounded in the philosophical frameworks of Utilitarianism and Kantian Deontology, focusing on the cognitive theory of moral status. While the law seeks to advance children's autonomy, the absence of clear, standardised guidelines for assessing maturity and mental capacity poses significant practical and ethical concerns. Utilitarianism reveals that limited healthcare resources and understaffed mental health services may result in decisions prioritising societal utility at the expense of individual rights. Kantian ethics challenges the subjective and inconsistent nature of capacity assessments, arguing that such practices violate the principles of universality and treating individuals as ends in themselves. Both frameworks suggest that Section 129(2), though well-intentioned, is ethically flawed in implementation. The paper concludes that the current legal position inadequately protects children's autonomy and calls for the development of objective tools and clearer guidelines to enable ethical application of the law in practice.
**Keywords:** Kantian, consent, children, autonomy, ethics and law

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## Introduction

Informed consent is a crucial concept in medical law and ethics that allows individuals to exercise their legal right to make decisions regarding their healthcare. Autonomy can be defined as the ability of an individual to make independent choices without external influences [1]. In medical decision-making, autonomy is expressed through informed consent, which recognises an individual's right to self-determination and freedom of choice [1]. Essentially, informed consent is a legal concept rooted in the ethical principle of respecting an individual's autonomy [2]. While obtaining informed consent from adults is generally straightforward, dealing with children becomes more complicated. Historically, children were not permitted to provide consent for medical treatment, primarily to protect them from the potential negative consequences of their immaturity [3]. However, the ratification of the United Nations Convention on the Rights of the Child (hereinafter referred to as UNCRC) marked a significant advancement in acknowledging

the evolving capacities of children [4]. This treaty recognises that as children develop, they gain the ability to understand and make informed decisions regarding their own health and well-being [5]. As a result, children are now granted the right to consent to certain medical decisions that directly affect them. Furthermore, even when they are not legally able to give full consent, they are encouraged to participate actively in the decision-making process [5].

South African law allows children aged 12 and older to consent to medical treatment without parental approval [6]. However, the validity of this consent depends on the healthcare professional's evaluation of the child's maturity and mental capacity to understand the benefits and consequences of the proposed treatment, as outlined in Section 129(2) of the Children's Act 38 of 2005 (hereinafter referred to as CA). Section 129(2) aims to promote children's rights and ensure that their views are considered in medical decision-making. Despite these commendable intentions, which align with international standards recognising children's evolving capacity to participate in decision-making, Section 129(2) presents significant challenges for healthcare professionals. Children hold a unique position within the moral and legal community [7]. They are recognised as individuals with rights; therefore, their needs and interests must be protected [7]. However, compared to adults, their rights are more limited. For instance, they cannot independently consent to medical treatment as adults can. Section 129(2) highlights that children can only give consent if they have been assessed to have sufficient maturity and mental capacity to understand the benefits and consequences of the treatment, a requirement that is not available when dealing with adults [6]. This discrepancy raises significant questions about children's rights and responsibilities, what they are morally entitled to, and how adults and the state should treat them [8].

The enactment of Section 129(2) was a much-needed reform, allowing children aged 12 and older to access healthcare without parental consent [9]. This change was particularly important given that South Africa was experiencing a high burden of HIV/AIDS-related deaths, which left many young children without parents and living in child-headed households [9]. However, this provision of the Act also creates serious ethical challenges for healthcare professionals. Three challenges can be identified regarding the provisions of Section 129(2). The first challenge is the lack of clear guidelines on how maturity and mental capacity should be understood and assessed [10]. The legislation does not define what constitutes maturity or how health professionals should evaluate this concept [10]. This underscores the critical challenge of involving children in medical decision-making and obtaining informed consent. Almost two decades after the CA was enacted in 2005, there have been no empirical studies published in South Africa that detail how health professionals currently involve children in medical decision-making and secure informed consent. Research on the adult population in South Africa identifies significant challenges in obtaining informed consent, such as language barriers, a lack of interpreters, limited time for health professionals to properly secure consent due to heavy workloads [2], and an overall shortage of staff [11]. It is argued that if obtaining informed consent is challenging among adults, it is likely to be even more complex for children. This is due to their varying levels of maturity, limited language skills, and lack of experience in making medical decisions [12].

The second challenge relates to the current state of the healthcare system in South Africa, where there is a significant shortage of health professionals, particularly in the field of mental health [13]. This is particularly concerning when evaluating children's maturity and mental capacity to consent to medical treatment. The field of child and adolescent mental health is severely understaffed [11]. Reports indicate that only three of the nine provinces in the country offer specialised services for child and adolescent mental health [11]. These specialists are essential for assessing children's maturity and emotional capacity. However, adding this responsibility to the already limited staff could overwhelm the system, which is already under significant strain. The last challenge is the absence of standardised assessments for evaluating children's maturity and mental capacity that can be applied consistently to all children without bias [14-15]Click or tap here to enter text.. This lack of uniform tools can result in inconsistent assessment outcomes, as health professionals may

rely on intuitive and non-standardised methods [16]. Such practices can undermine the validity and reliability of assessments [14], ultimately affecting children's rights to autonomy.

The question being asked in this paper is whether Section 129(2) of the CA is ethically justified in promoting children's right to autonomy, particularly when analysed through the frameworks of Utilitarianism and Kantian Deontology. The authors argue that, in the absence of clear guidelines for assessing children's maturity and mental capacity, Section 129(2) cannot be justified from either a Utilitarian or Kantian Deontological perspective. To support this argument, they will examine theories of moral status through the lens of cognitive capacities theory. Section 129(2) addresses the maturity and mental capacity of children to consent to medical treatment. The authors contend that mental capacity, in this context, refers to a child's cognitive ability to understand the benefits and consequences of the proposed treatment, which aligns with cognitive properties in moral status theory. They assert that children can be considered moral agents only if they possess the rationality and higher order thinking necessary to comprehend the implications of the treatment. Therefore, assessing maturity and mental capacity is essential before children can unilaterally consent to medical treatment.

After examining children's moral status through the lens of cognitive theory, authors will specifically explore whether Section 129(2) could infringe upon children's rights when evaluated from the ethical perspectives of Utilitarianism and Kantian Deontology. Utilitarianism seeks to maximise overall well-being for the greatest number of people. When applying this perspective to Section 129(2), it is essential to balance the need to assess children's mental capacity and maturity with the health needs of the broader community. The utilitarian argument focuses on determining whether the investments made under this section yield greater overall benefits compared to improving mental health facilities for the wider population. 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 [17]. If health professionals apply Section 129(2) inconsistently, this violates Kant’s principle of universality. Therefore, without clear guidelines and objective assessment tools that can be applied consistently to all children, Kant's deontology does not ethically justify Section 129(2).

**Understanding Moral Status**

In modern ethics, a crucial question concerns which entities should be recognised as having moral status [18]. Having moral status means that an entity is protected by moral norms that guide how individuals should behave [8]. This status significantly affects the treatment of the entity, and the legal, political, social, and economic systems established to respect it [8]. There are two primary reasons why an entity may be regarded as possessing moral status. The first reason is based on the notion that the entity possesses a specific property that grants it status [1]. The second reason is that if entities have moral status, they also have a set of rights and interests that are morally important [18]. This means we have ethical reasons to protect them.

Five theories of moral status examine how individuals attain moral standing [1]. The traditional account of moral status grants individuals’ moral status based on specific human characteristics unique to Homo sapiens [1]. Specifically, it posits that individuals can only obtain moral status if they are conceived by human parents or possess a human genetic code [19]. The second theory focuses on moral agency, which suggests that individuals attain moral status when they can act as moral agents [19]. According to this theory, a person is considered to have moral agency if they can make moral judgments regarding the rightness or wrongness of their actions [19]. Furthermore, this status is dependent on having motives that can be morally evaluated. The third theory focuses on sentience, the capacity to feel pain and pleasure [1]. The fourth theory of moral status emphasises relational properties. This perspective asserts that relationships, especially those that define roles and obligations, like doctor-patient relationships, determine moral status [1]. The fifth and last moral status theory, which will be the basis of this paper, focuses on cognitive properties.

Cognition refers to the processes of awareness, including perception, memory, understanding, and thinking [1]. Beauchamp and Childress argue that individuals hold moral status if they possess qualities such as self-awareness, freedom to act, capacity for language-based communication, and the ability to reason about their actions [1]. Section 129(2) mentions children's maturity and mental capacity, which relate to their cognitive abilities to understand the benefits and consequences of proposed treatments. The theory of cognitive properties suggests that individuals have moral status due to their capacity for self-reflection through cognitive abilities and their self-determination based on beliefs [19]. This distinguishes them from individuals who lack these competencies and from nonhuman animals. Once children demonstrate the maturity and mental capacity to understand the benefits and consequences of a proposed treatment, health professionals have a responsibility to respect their rights to autonomy and self-determination [20]. This means that children should be allowed to consent to their own medical treatment. When individuals are recognised as having moral status, they acquire a specific set of rights and interests that are morally significant; therefore, we have an obligation to safeguard them [18].

**Philosophical Approaches To Medical Ethics**

- **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 [17]. 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 it will 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 [21] weighing the balance of good and bad consequences. 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" [21]. 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 [22]. 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), utilitarianism focuses 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 [23]. This means that utilitarians are likely to consider the entire health system and evaluate whether applying Section 129(2) will bring about the greatest good to most people within the mental health system. The focus on mental health facilities is because mental health professionals, such as psychologists, are best suited to assess children's maturity and mental capacity, as it falls within their scope of practice as highlighted in Section 37(2)(a) to (h), of the South African Health Professions Act 56 of 1974 (hereinafter referred to as HPA). HPA defines the following activities as pertaining to the profession of a psychologist: Evaluating behaviour or mental processes by interpreting tests for intellectual abilities and diagnosing personality, emotional, and cognitive deficiencies, and assessing and adjusting the emotional, behavioural, and cognitive processes of individuals or groups using questionnaires and tests and lastly, developing and overseeing the creation of assessments for intellectual abilities and psychophysiological or psychopathological functioning [24].

However, psychologists' assessment of children's maturity and mental capacity is likely to prove problematic in South Africa. According to statistics from the South African College of Applied Psychology released in 2018, only 27% of South Africans suffering from severe mental disorders receive the necessary treatment [13]. Additionally, it is noted that those who do receive treatment often do not remain in care and have inconsistent access to quality services [11]. This situation can be attributed to several factors, including a significant shortage of trained mental healthcare providers in South Africa, particularly in specialisations such as child and adolescent mental

health, which are frequently overlooked [11]. Nguse and Wassenaar explain that the mental health facilities may be struggling due to receiving only 5% of the national health budget [25]. Consequently, only 50% of public hospitals that offer mental health services have a psychiatrist, and about 30% lack a clinical psychologist [25]. This paints a picture of a mental health system in crisis.

In the current situation, evaluating children's maturity and mental capacity 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 like the Life Esidimeni tragedy, where mental health users were transferred to ill-prepared facilities due to cost-cutting measures [26]. On the other hand, assessing children's maturity and mental capacity may be overlooked due to the shortage of child and adolescent specialists [11]. This could lead to situations where children are either treated without assessing their ability to consent or are required to obtain parental consent [27]. 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. It is therefore submitted that 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 [17]. 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 [28]. This is particularly evident when the consent process involves a thorough evaluation to determine whether the child has the maturity and mental capacity to consent. It is essential to consider this issue, considering the resources available within the country, especially when it comes to mental health services [13]. Although utilitarians aim to prioritise impartiality and overall well-being when allocating healthcare resources, a trade-off must be made to ensure that resources are distributed to maximise utility for the greatest number of people [21]. Therefore, given that the mental health budget in South Africa is about 5% of the entire health budget [25], there is a severe shortage of children's mental health specialists [11]. Utilitarians might view the loss of freedom for some children as made right by a greater good shared by others.

**Utilitarianism And Paternalism In Children**

Paternalism is frequently referenced in children's rights scholarship, both explicitly [29] and implicitly [27]. The act of paternalism involves overriding an individual's decisions in the name of their safety, well-being, or other harm prevention objectives [29]. Historically, the medical field operated under the belief that health professionals should prioritise the well-being of patients over their autonomy [30]. This approach assumed that medical experts knew what was best for patients and made decisions on their behalf. A key argument against paternalism is rooted in the liberal belief that individuals are best able to understand their own interests and values through personal reasoning [29]. Therefore, they should have the freedom to make their own decisions and accept the consequences of those choices. This perspective has led to a heightened respect for autonomy, focusing on shared decision-making [2].

Respect for autonomy emphasises collaboration between healthcare professionals and patients to make medical choices that align with the patient's values and preferences [2]. However, this perspective emphasises the authority of a hypothetical "competent adult" over the paternalistic prioritisation of assumed well-being [30]. When discussing children, it is important to adjust our reasoning because of their unique position in both legal and ethical contexts [7]. Children are recognised as having rights, and their voices should be heard. However, due to their immaturity, they are considered vulnerable and in need of protection [29]. This inherent vulnerability is often cited as a justification for safeguarding children's rights, which can lead to paternalism [29]. In

contrast, applying paternalism to adults is seen as morally problematic because adults are presumed to have the capacity to make their own choices.

The UN Committee on the Rights of the Child recognises that some children are more vulnerable than others [31]. In General Comment 13, the Committee identifies circumstances that can increase children's vulnerability, including chronic illness, low socioeconomic status, the effects of conflicts or natural disasters, disabilities, and the experience of abuse [31]. It is this vulnerability that makes paternalism acceptable for children, as it is often necessary to protect them from the negative consequences of their poor decision-making [29]. While paternalism is generally viewed as ethically wrong, there are specific scenarios in which it may be considered permissible from a utilitarian perspective. In South Africa, paternalism can be viewed as permissible, given the vulnerabilities of many children in the country. South Africa is often described as an unequal society characterised by uneven distribution of resources [32].

A review by UNICEF and the South African Human Rights Commission (2011) highlights a significant disparity between children from the wealthiest and poorest quintiles [32]. Children in the poorest quintiles are less likely to have access to early childhood education, complete secondary school, or obtain medical aid, often relying on the public health system [32]. These factors are crucial in assessing children's maturity, which is not determined solely by age but also influenced by aspects such as an individual's background, exposure to information, life experiences, environment, and levels of support [12]. This suggests that children raised in affluent areas, who have access to favourable conditions, such as information, strong support systems, and quality healthcare, may be perceived as more mature. In contrast, children who grow up in impoverished areas, facing unfavourable conditions like poor environments, lack of support, and limited access to information, may be seen as lacking maturity.

Since paternalism is based on the idea of coercing someone for their own good, utilitarianism justifies intervention only if it genuinely benefits the person being coerced and ultimately maximises overall utility [33]. From this perspective, the fact that children tend to make poor choices is relevant because such decisions can decrease overall welfare [33]. This view is further justified by Daly, who states that throughout history, children have not been allowed to perform juristic acts, such as consenting to their medical treatment [34]. Kruger further highlights that an important objective for the limitation of the capacity of children is to protect them from their immaturity of judgment [3]. Therefore, children are seen as legitimate subjects of paternalism because, if given equal status, they may cause avoidable suffering to themselves or others, or both. The argument is that any additional harm resulting from a policy of paternalistic intervention must be outweighed by the benefits it produces [7].

In terms of Section 129(2), utilitarians might concur that evaluating children's maturity and mental capacity protects them from immaturity, maximising overall societal benefit. However, they might argue that this objective is not being met due to the intricacies of such assessments and the absence of clear guidelines on their administration. Consequently, paternalism may be a preferable alternative because it is justified from a utilitarian perspective if it leads to the best outcomes. Godwin argues that in cases of paternalistic acts, the benefits to the individual must outweigh any potential harm to their interests [33]. 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. One could also argue that Section 28(2) of the Constitution of the Republic of South Africa 1996 emphasises that the best interest of the child is paramount in every decision that affects them [35]. This principle is certainly relevant in this situation. One could argue that acts of paternalism, if executed with the child's best interest in mind, can be ethically justified.

The argument can be made that the benefits of health professionals acting paternalistically in the best interest of the child outweigh the consequences of subjecting children to intuitive assessments, which may be biased and invalid. The ‘best interest of the child’ is probably the main area in which

paternalism is most prominent, especially in situations of enhanced vulnerability [29]. Hence, this principle could be used to justify paternalistic acts, as according to Skelton, this principle serves to guide decisions regarding children and furthermore defines and limits competing rights that may arise [36]. It is furthermore Cantwell's view that the concept of 'best interests' can address gaps in rights provisions, but it shouldn't be seen as the foundation for ensuring the human rights of all children [37]. In this context, one might argue that since there is a lack of guidelines in the legislation on how to assess children's maturity and mental capacity, health professionals could rely on the principle of the child's best interests to decide whether a child should receive treatment.

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 [29]. The argument could, therefore, be made that using paternalism far outweighs the consequences of assessing mental capacity and places an extra burden on the government to provide resources for such assessments. Since there are no standardised tests [14], each health professional might use intuitive assessments [34], which might produce correct or incorrect conclusions about children's capacity to consent. As Herring 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 [38]. Similarly, if they are assessed as not having capacity while they do, they could lose their right to consent to medical treatment [38]. Therefore, Section 129(2) is not ethically justified from a utilitarian point of view because it will likely not produce overall utility for the greatest number of children without clear guidelines on how maturity assessments should be conducted.

**Kantian Deontology**

Deontological ethics determines "the moral status of an action based on principles such as justice, rights, or fairness", rather than its consequences [21]. 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 [1]. 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" [39]. According to Kant, the morality of a choice is determined by its alignment with moral norms that every moral agent should adhere to, rather than maximising benefits for oneself [39]. In this view, Kant's deontology prioritises what is morally right over 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 all our duties can be derived from the "categorical imperative" [40]. The "categorical imperative" can be regarded as a universal law which is objective, necessary, and unconditional [39]. It dictates that we must follow it even if it goes against our natural desires.

**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 [40]. According to Kant, respect for autonomy is applicable only to individuals who are autonomous; it does not extend to those who cannot act independently or autonomously [22]. Kant argues that their capacity for rationality sets humans apart from non-human animals [7]. According to Kant, rationality can only be achieved through reasoning that others cannot reasonably dispute [41]. However, when it comes to children, Baines argues that significant adults, such as parents or health professionals, often overlook children's perspectives and reasoning and, therefore, cannot be considered fully autonomous [42]. Peleg further supports this argument by challenging Article 12 of the UNCRC. Peleg contends that while the article claims to protect children's right to participate in decision-making, it effectively grants adults the authority to determine how and to what extent children can participate [29]. This dynamic allows adults to label children as immature, which can ultimately silence their voices. The perception of children as immature has historical roots and has often been cited as a reason for restricting their

ability to engage in legal acts [3]. The prevailing argument is that children are being protected from the potential consequences of their supposed immaturity.

The argument extends beyond just the immaturity of children. In medical decision-making, it is important to evaluate whether children possess the rationality and understanding necessary to comprehend the benefits and consequences of treatment. This assessment is crucial for determining their ability to provide independent consent. Moritz argues that the complexity of children's reasoning is influenced by their maturity [43]. Therefore, assessing a child's maturity and mental capacity is a complex and challenging task due to the many factors that affect individual decision-making [9]. It is Wall's argument that while some children may be capable of rational and independent reasoning, many, especially younger ones, may lack this ability [44]. Furthermore, maturity itself is shaped by various factors, including the complexity of the information being shared, the child's cognitive ability to understand that information, the environment in which the decision-making occurs, and the behaviour of others [12].

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. Kant's stance aligns with the current legal position, where children occupy a unique and conflicting societal position [7]. On one hand, children have rights; however, due to their immaturity, they are excluded from certain legal actions [3]. Paron identifies this conflicting position as a fundamental paradox in children's rights. This paradox reveals that while children are recognised as subjects of rights, they do not have the same level of autonomy as adults [45]. This situation can be traced to Article 12 of the UNCRC, which presents two somewhat conflicting perspectives. On one hand, it states that "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child" [5] On the other side, however, it highlights that 'the views of the child being given due weight in accordance with the age and maturity of the child'' [5]. The gradual shift toward full autonomy, described in the UNCRC as "evolving capacities," poses challenges in establishing legal norms concerning the legal capacity of children in real-world situations [45]. This context may clarify why theories concerning Article 12 emphasise the idea of "participation rights." According to Paron, while children are included in decision-making processes, they often do not have the authority to make the final decisions [45].

Kant argues that, although children do not yet have full autonomy, they still belong to the universal human community and should be treated with dignity and respect [44]. He believes that children possess the inherent potential for rationality and autonomy. Even if they are not mature enough to make certain decisions, Kant maintains that they have the capacity to develop into fully autonomous individuals [44]. Therefore, they deserve to be treated with dignity. In the medical context, where children need to consent, the default position is to assess their maturity and mental capacity first to ensure they understand the benefits and consequences of any proposed treatment. One could argue that this aligns 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 establish whether they can provide valid consent. However, assessing children's maturity and ability to consent is challenging due to the lack of consensus on how to conduct such assessments [46]. 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 can exercise autonomy.

**Kant and categorical imperatives**

According to Ramaswamy, in Kant's view, the legitimacy of any act can be tested using two categorical imperatives [47]. An act must be compatible with both categorical imperatives to be deemed legitimate and permissible. Per Kant, the act must not be performed if even one of the two imperatives renders an act impossible or redundant [47]. The first categorical imperative posits that an action should be formulated as a universal law without leading to any contradictions [47]. Section 129(2) fails to meet this principle for two reasons. Firstly, clear guidelines are essential for the consistent nationwide implementation of Section 129(2), thereby adhering to the principle of universalism. Without guidelines, each health professional relies on their own experience, intuition, and knowledge to determine if children can consent [48]. Therefore, guidelines become crucial as they improve the consistency and efficiency of the process, bridging the gap between clinical practice and scientific evidence [49]. In this way, guidelines ensure that assessing 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.

Additionally, standardised assessment instruments or tools do not exist to evaluate children's maturity and mental capacity. This situation is further complicated by the lack of consensus among health professionals on how to define maturity [46]. As a result, confusion and inconsistency arise among health professionals in applying Section 129(2). Without objective, standardised assessment tools, each health practitioner relies on subjective assessments to determine whether a child can consent [48]. According to Kant, this subjective approach is morally wrong as it contradicts the maxim of universality. Kant's ethical system is grounded in reason rather than intuition [39]. He asserts that a moral individual must be rational [39], which suggests that health professionals should rely on rationality when assessing children's maturity instead of intuition. From Kant's perspective on rationality and reason, health professionals need to conduct assessments in an objective and consistent manner. They should base their decisions on objective assessment tools rather than relying on intuitive measures. Furthermore, in the absence of standardised objective assessments, the law is likely to be inconsistently applied, leading to varied approaches among health professionals. Some provide treatment without assessing the child's consent, while others refuse treatment to children without parental consent [27].

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 [22]. 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, thus taking away their dignity and self-worth as autonomous agents [50]. In medical decision-making, informed consent can be described as an autonomous authorisation by the individual for the medical intervention [2]. Health professionals recognise the ethical principle that each individual has the right to make decisions about their own body by allowing patients to provide informed consent. This practice respects the dignity and autonomy of individuals, acknowledging their right to choose whether to accept or refuse treatment. Rather than treating people as mere means to an end, health professionals treat them as autonomous beings with their own rights. 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 [2]. Although children cannot legally provide informed consent and are not recognised as fully autonomous beings, Kant emphasises that they belong to the universal human community [44]. Because they possess a rational capacity, children deserve to be treated with dignity and respect [44]. Treating people as ends in themselves provides the foundation that everyone deserves a minimum standard of dignity to sustain human co-existence without coercion [50]. Section 10 of the Constitution of the Republic of South Africa holds a similar view to Kant and affirms that everyone has inherent dignity and the right to have that dignity respected and protected [35]. As noted by Skelton, while Section 28 extensively outlines children's rights, children are entitled to all other rights recognised in the Constitution as well [36]. A clear illustration of this can be seen in court rulings such as *S v Williams and Others (1995) 3 SA 632 (CC)* [51] and *Christian Education South Africa v Minister of Education (2000) 4 SA 757 (CC)* [52]. In these cases, the courts acknowledged the

importance of upholding all constitutional rights for children and applied additional rights to them, even when those rights are not explicitly mentioned in Section 28.

In his writing on education, Kant emphasised that education is significant in ensuring that people can fully consent and exercise their autonomy [7]. Kant argues that a lack of education invalidates consent due to a lack of information, affecting a person's ability to exercise their right to autonomy [6]. The ruling in *Castell v De Greef 1994 (4) SA 408 (C)* illustrates a similar viewpoint, as it lays the foundation for the doctrine of informed consent in South Africa [53]. According to this case, the minimum acceptable standard for consent under South African law mandates that the consenting individual must have knowledge of and be aware of the nature and extent of any harm or risk involved [53]. This means that patients need to be adequately informed to exercise their autonomy. Additionally, the information provided must be comprehensive, covering the entire transaction and all its potential consequences [53].

Kant argues that teaching students how to think and act according to principles, rather than out of fear or self-interest, is crucial [54]. It is important to guide them in respecting rules while also helping them develop a sense of their own freedom and value [54]. This implies the need to educate children about the need for their rights and restrictions, as this fulfils the imperative to treat them with dignity and respect. In failing to educate children about their rights, and why it is important that there are restrictions on their rights. In this manner, Kant believes that the child's mind is being nurtured to become independent and self-sufficient in the future [7]. Neglecting to educate children and equip them with the understanding necessary for maturity and mental capacity assessments violates Kant's categorical imperative. This principle emphasises that we should not treat individuals merely as a means but rather respect their inherent dignity.

A similar view is expressed by the UNRC Committee's General Comment 20 (paragraph 18), which emphasises the concept of evolving capacities, describing it as an enabling principle [4]. This principle recognises the process of maturation and learning through which children gradually acquire competencies, understanding, and increasing levels of agency [4]. As children grow, they become more capable of taking responsibility for and exercising their rights. However, the authors argue that this perspective is still problematic because it inherently involves paternalism. It enables adults to maintain control over children by determining their autonomy based on assessments made by adults [29]. Furthermore, in a diverse country like South Africa, the issue becomes even more complex due to a lack of assessment tools for evaluating children's maturity and mental capacity [46]. It is Daly's 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 [34]. In this context, health professionals may justify decisions regarding children's capacity to consent without empirical data, leading to biased and unfair assessments. Additionally, there are no clear guidelines for how children's maturity should be assessed, contributing to confusion and inconsistency.

Furthermore, General Comment 12 (paragraph 84) elaborates that the more a child knows, experiences, and understands, the more the parent, legal guardian, or other responsible individuals must shift their role from providing strict direction and guidance to offering reminders and advice [5]. Ultimately, this transition should evolve into a partnership where discussions occur on equal footing. Therefore, Kant suggests that health professionals should educate children about their rights and the importance of assessing their maturity. However, achieving this in the South African context is likely to be difficult. The study by Chima highlights that language creates a significant obstacle in obtaining informed consent, especially in public hospitals [2]. 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 [9]. They should consider the child's age,

gender, background, and the emotional impact this news will have on the child. It is important to remember that when communicating with children, it is crucial to ensure they understand the information being conveyed. This understanding is essential for them to make well-informed decisions. Per Kruger, understanding in this context isn't just an abstract process [3]. It also requires grasping the nature and significance of potential choices and incorporating this comprehension into the decision-making process [3]. Kruger 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 [2], 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.

Applying 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. 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 [7]. The goal is to help children understand how to endure the limitations on their freedom while also learning to use their freedom wisely [54]. In the context of Section 129(2), health professionals themselves do not seem to be aware of the existence of this section and the reasons behind these assessments [27]. It then becomes challenging when they must 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, according to Kant, Section 129(2) will fail in the maxim of not treating people as mere means to an end.

**Conclusion**

Section 129(2) of the South African Children's Act 38 of 2005 represents a significant attempt to align South African law with international norms that recognise the evolving capacities of children. It acknowledges that children, especially those over the age of 12, may possess sufficient maturity to participate meaningfully in decisions concerning their medical treatment. However, as this article has demonstrated, the ethical legitimacy of this provision is undermined by the lack of standardised tools and clear criteria for assessing children's maturity and mental capacity.

From a utilitarian perspective, although the aim of Section 129(2) is to maximise the well-being of children and promote public health access, the severe shortage of mental health professionals and limited budget allocations render consistent implementation nearly impossible. This compromises the rights of the very children the provision aims to protect. Moreover, utilitarianism's emphasis on the greatest good for the greatest number often results in the marginalisation of vulnerable individuals. In this case, it may justify paternalistic actions that override children's autonomy, especially when resources are constrained.

From a Kantian deontological standpoint, the lack of uniform guidelines and standardised assessments violates the moral duty to treat children as ends in themselves rather than as means to administrative efficiency or institutional convenience. Kantian ethics demands that all individuals be treated with dignity and that rules be applied consistently and universally. Subjective assessments based on intuition contradict this imperative, creating ethical uncertainty and risking both under- and over-protection of children's rights.

Both frameworks thus converge on the conclusion that while Section 129(2) is normatively defensible in theory, it is ethically problematic in its current form. Without objective, reliable measures to assess a child's capacity to consent, and without sufficient institutional support to implement such assessments, the provision falls short of upholding children's rights to autonomy and dignity. The state, therefore, has a moral obligation to develop contextually appropriate, evidence-based guidelines and to invest in health system strengthening, particularly in child mental health services. Only then can Section 129(2) be ethically implemented in a manner that genuinely respects and promotes the autonomy of children within a just and functional healthcare system.

To address the significant ethical and practical concerns raised by Section 129(2) of the Children's Act, a series of concrete reforms must be undertaken. First and foremost, the South African

Department of Health, in collaboration with the Health Professions Council of South Africa (HPCSA), should develop clear national guidelines to standardise the assessment of children's maturity and mental capacity. These guidelines should define the cognitive and emotional criteria necessary for informed consent and provide structured, evidence-based tools for evaluating such criteria in a clinical setting. Standardised procedures will mitigate reliance on subjective intuition and ensure that children are evaluated fairly and consistently across healthcare institutions.

In conjunction with the development of these guidelines, health professionals should receive specialised training in the ethical and legal dimensions of consent in paediatric care. This training should form part of both undergraduate medical education and continuing professional development initiatives. It must include instruction in ethical theories, legal obligations under Section 129(2), and culturally appropriate communication strategies to engage effectively with children and their families. Equipping practitioners with this knowledge is essential for fostering ethical decision-making and safeguarding children's rights in clinical contexts.

Additionally, the government should invest in expanding the presence of multidisciplinary mental health teams within public healthcare facilities. These teams, comprising psychologists, social workers, and paediatricians, would collaboratively assess children's mental capacity, allowing for shared responsibility in ethically complex cases. This model would also alleviate the pressure on individual practitioners, who may lack the time or expertise to conduct assessments independently. In parallel, the legal framework should be amended to explicitly mandate child participation in medical decision-making, in line with Article 12 of the UN Convention on the Rights of the Child. This would require that children's views be solicited and meaningfully considered, regardless of whether they are ultimately deemed capable of giving consent. Tools such as child-friendly educational materials and participatory checklists should be integrated into consent procedures to ensure that children's agency is respected.

To further support the ethical implementation of Section 129(2), broader educational reforms are necessary. Health literacy campaigns and school-based programmes should be introduced to educate children about their health rights, the importance of informed consent, and how to navigate medical decision-making. Early and sustained health education would promote a culture of autonomy and ensure that children are better prepared to participate in their own healthcare. Finally, a monitoring and accountability mechanism should be established to oversee the implementation of Section 129(2). This body would be responsible for auditing practices across provinces, tracking inconsistencies in consent assessments, and publishing periodic reports that inform future legislative reform. Legislative amendments to Section 129(2) itself should also be considered, particularly to provide statutory definitions for "maturity" and "mental capacity" and to formalise the requirement that such assessments be carried out using objective, standardised tools. These recommendations, taken together, would not only strengthen the ethical grounding of Section 129(2) but also enhance the ability of the healthcare system to realise children's rights in practice.

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