When the Inherent Authority of the High Court Trumps Parental Authority in Medical Decision-Making Involving the Withdrawal of Life Support Treatment Affecting Minor Children and their Parents

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Abstract

Judges are often up against very grave cases when they have to decide whether to order the withdrawal of life support from children who are seriously ill or in a vegetative state. What is more, medical practitioners attending to the medical care of the child affected, believe that clinically it would be in the best interest of the child that his or her life should be terminated. Any continued medical treatment would be futile. The parent(s) on the other hand do not agree with the medical team. Because the parties involved cannot reach agreement the dispute is consequently referred to the High Court. It is then up to the court to make the final decision. In this triad, some of the fundamental legal issues to be decided, include: who should have the final say over the withdrawal of life support treatment for minor patient? What criteria does the court use in resolving the dispute between the parties? This article provides a critical insight into when the High Court's inherent authority trumps parental authority in end-of-life decision making affecting minor children. What will become apparent is that the South African High Court has only sporadically been asked to exercise their inherent authority to interfere with a parent's decision-making power when, because of religious reasons, parents refuse to consent to their children being exposed to blood transfusions. Here, the High Court has often come to the rescue of children by adopting an orthodox approach. The court will firstly, in search of the welfare of the child, exercise its authority as upper guardian of children. Secondly, the court will search for the welfare of the child under the rubric of "what is in the best interest of the child". The South African High Court, unlike its English counter-part, has not been exposed to cases dealing with end-of-life decisions involving children. What is called for is for the South African courts to develop its own jurisprudence. A likely starting point would be for consideration to be given to South African domestic law, including the *Constitution*, the common law and customary law infusing African jurisprudence. To this end, the South African High Court is also urged to consider the well-developed criteria found in the English cases. But, before the parties engage in litigation, where possible, mediation should be attempted.

Keywords

Best interests of the minor child; blood transfusions; withdrawing life support; end-of-life decision making; consent; comparative law; constitutional imperatives; foreign law; African jurisprudence; *Children's Act*; inherent authority of the High Court; mediation before litigation; sensitivity training.

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1 Introduction

Judges, the world over are often faced with complex cases in which they are expected to decide disputes having a profound effect on the lives of children.[1] In a medical context, the South African High Courts have sporadically faced the daunting task of deciding *inter alia* whether to preserve or sustain the lives of minor children, very much against the wishes of their parents who object for example, on religious grounds to their children receiving blood transfusions.[2]

What is more, judges in England are often up against even graver cases when they have to decide whether to order the withdrawal of life support treatment from children who are seriously ill or in a vegetative state. South African courts unlike their English counterparts, have hitherto escaped making those difficult and often solemn decisions.[3] Here, the parents are often in dispute with the medical practitioners attending to the medical care of the children. Because they are unable to resolve their differences, the courts frequently find itself caught in the middle, ultimately having to decide whether to order the ending of the child-patient's life or not.[4] Ironically, in this triad, parents, healthcare practitioners and courts, all believe that the action proffered by them is generally in the child's best interests.

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1 For cases in South Africa see *S v M* 2008 3 SA 232 (CC) on the effect of a custodial sentence for a primary care giver of minor children; *M v M* (15986/2016) [2018] ZAGPJHC 4 (22 January 2018) regarding the difficulty judges face in matters involving acrimonious parents and the effect on children; see also *Michael v Linksfield Park Clinic (Pty) Ltd* 2002 1 All SA 384 (A) on the difficulty a court faces when pronouncing a judgment where negligence had not been proven in a case involving a 17-year-old who became a quadriplegic after surgery.

2 See the cases of *S v L* 1992 3 SA 713 (E); *Hay v B* 2003 3 SA 492 (W) (hereafter the *Hay* case); and the more recent decision of *Life Health Care Group (Pty) Ltd v JMS (As Parent and Guardian of the Infant Child MT)* (34758/2014) [2014] ZAGPJHC 299 (20 October 2014) (hereafter the *Life Health Care Group (Pty) Ltd* case).

3 For the English cases see *Barts Health NHS Trust and Hollie Dance and Paul Battersbee and Archie Battersbee (Through His 16.4 Guardian)* [2022] EWHC 1435 (Fam) (hereafter the *Hollie Dance* case); *Fixsler v Manchester University NHS Foundation Trust* [2021] EWCA Civ 1018 (9 July 2021) (hereafter the *Fixsler* case); *Great Ormond Street Hospital and Yates and Gard* [2017] EWHL 972 (Fam) (hereafter the *Yates and Gard* case).

4 For the English cases see the *Hollie Dance* case; the *Fixsler* case; and the *Yates and Gard* case.

End-of-life decisions hastening the death of the minor child-patients are often wrought with religious, ethical, legal and emotional challenges.[5] An important challenge that confronts the courts is to strike an acceptable balance between respecting parental authority and protecting the child patients.[6] Another challenge includes the State's legitimate interference with the parental decision-making capacity in relation to medical treatment of minors.[7]

There appears to be a lack of clarity in the South African law as to how the courts are likely to approach this very contentious issue. What we do know is that our courts when trying to resolve the issue, are likely to rely on two fundamental principles, namely what is in the best interest of the child and using its authority as the upper guardian of minor children.[8] The best interest of the child has on occasion been described as "the essential building block in the foundational wall of medical law and ethics".[9]

Both the South African *Constitution*[10] and applicable legislation[11] also form part of the protective measures in favour of minor children. The *Constitution* also has a developmental role, especially when the common law needs to be developed.[12] Judges are the custodians of the common law and the architects of its development.[13] Given the topic at hand, it may be necessary and in public interests that the South African courts develop our jurisprudence in end-of-life decision making cases involving minor patients. Because the South African *Constitution* is the supreme law of the land and governs the lives and conduct of its citizens and healthcare providers,[14] in the so-called end-to-life decision making cases, the courts are obliged to invoke the Bill of Rights[15] including *inter alia* "the best interests of the child

5 Van Aswegen and Nienaber 2017 *THRHR* (2) 553; for the English case law see *Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) (3 October 2019) (hereafter the *Raqeeb* case); the *Fixsler* case para 34; and the *Hollie Dance* case 1435.

6 See the *Hollie Dance* case 1435; the *Fixsler* case 1018.

7 Auckland and Goold 2019 *CLJ* 287.

8 For the South African decision see the *Hay* case 492.

9 Van Aswegen and Nienaber 2017 *THRHR* (1) 438; Malherbe and Govindjee 2010 *THRHR* 61.

10 The *Constitution of the Republic of South Africa*, 1996 (the *Constitution*).

11 The *Children's Act* 38 of 2005 and the *National Health Act* 61 of 2003.

12 See s 39(2) of *the Constitution*.

13 See *Thebus v S* 2003 6 SA 505 (CC) para 31.

14 Section 2 of the *Constitution*, also known as the supremacy clause, provides that: "the Constitution is the supreme law of the Republic; law and conduct inconsistent with it is invalid, and the obligations imposed by it must be fulfilled"; see also s 172 of the *Constitution* on the powers of the courts in constitutional matters, including orders that are just and equitable.

15 Chapter 2 of the *Constitution.*

in every matter concerning the child";[16] the right to human dignity;[17] "the right to life";[18] and "the right to freedom and security of person".[19]

Because of the consistency and thoroughness that the English courts have shown, it is suggested that the South African courts where possible approach the decision-making process along the lines of the English legal system.[20] That will ensure that the proposed law reform is substantial and real, not merely theoretical and rhetorical.

Consequently, this article will traverse the South African and English legal positions with regard to end-of-life decisions hastening the death of minor children, where sustaining children's lives would be futile.

In this triad involving the parents, the medical practitioners and the court, some of the fundamental issues caused to be decided include: who should have the final say over the withdrawal of life support treatment for minor patients? What criteria does the court use in resolving the dispute between parents of the minor patients and the medical teams overseeing the treatment of the patients?

2 Background

Making decisions as to the lawfulness of the withdrawal of life-sustaining treatment involving children, have featured prominently in the last few decades in England.[21] Those situations may generally arise from children born with *inter alia* neurological disabilities and respiratory failures.[22] Absent are vital signs of normal brain activities for example, responsiveness and interaction. There are also children born healthy but through a sparse and undetected event, develop an unusual condition, including irreversible brain damage.[23] What follows is that they are being kept alive by ventilators.[24] But, continued artificial ventilation resulting in prolonging the life of a heavily brain-damaged and physically challenged children in circumstances where they would inevitably die, have resulted in disputes between the parents and

16 See s 28(2) of the *Constitution.*
17 Section 10 of the *Constitution*.
18 Section 11 of the *Constitution.*
19 Section 12 of the *Constitution*.
20 Paris *et al* 2017 *Journal of Perinatology* 1268.
21 See the *Yates and Gard* case para 23; *King's College Hospital for Children NHS Foundation Trust v Ms Thomas, Mr Haastrup and Isaiah Haastrup* [2018] EWHC 127 (Fam) (hereafter the *Haastrup* case); see also the *Fixsler* case para 94 and the *Hollie Dance* case 1435.
22 The latter is the characteristic features of mitochondrial disease or mitochondrial DNA depletion syndrome, referred to generally as "MDDS"; see the *Yates* and *Gard* case paras 52 and 58.
23 See the *Hollie Dance* case 1435 regarding a child found with a ligature around the neck, leading to his brain stem death before the court decided that his life could be terminated.
24 See the *Hollie Dance* case 1435.

the children's medical practitioners.[25] On the one hand, the parents argue that by virtue of their particular relationship with their children, they are best placed to make decisions about what is truly in the best interest of the children. On the other hand, the medical practitioners overseeing the treatment of the children may, by virtue of their medical expertise and experience believe that the prolonged treatment given, may be a futile exercise and not in the child's best interests. Any efforts by the parents to sustain life under those circumstances goes against the interests of the individual child, and may be viewed by the medical team as unreasonable. Because the parties cannot resolve their differences, these cases invariably end up in the courts where the courts are asked to intervene. The key question raised in all these cases is who should have the ultimate say over a child's medical treatment?[26]

In these end-of-life cases, courts often face parents who contend that because their children cannot speak for themselves,[27] nor are they competent to consent to medical treatment themselves, the parents of the child patients understand best the needs of their children and make decisions accordingly.[28] The advancement of medical technology and the improved skills of medical practitioners to provide intensive invasive treatment to the dying, have increased the hopes of parents that their gravely ill child may survive this medical setback. They also pin their hopes on miracles that their children can be kept alive.[29] It may also be just too difficult to let a loved one go.[30] Because of the afore stated, the parents may argue that the withholding of treatment or the termination of life would be unreasonable. While there is life, there is hope. On the other hand, the medical team relying on the objective medical evidence, may adopt a contrary view, especially where they believe that the continuation of the treatment would be futile. They may hold the view that their end-of-life decision is reasonable whereas the parents are unreasonably withholding consent to terminate the child's life. The medical team may then approach the High court to override the parents' decision that they believe, exposes the child to significant harm.[31]

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25 Auckland and Goold 2019 *CLJ* 288.

26 Auckland and Goold 2019 *CLJ* 288-293.

27 See *Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] 2 WLR 480 (hereafter the *Conjoined Twins* case); see also the *Fixsler* case paras 81 and 82; for a South African perspective see Malherbe and Govindjee 2010 *THRHR* 61.

28 See the *Yates and Gard* case 972; also *Great Ormond Street Hospital for Children NHS Foundation Trust v Yates (No 2)* 2018 1 All FLR 623 (hereafter the *Yates* case); the *Hollie Dance* case 1435.

29 See the *Fixsler* case para 34.

30 See the *Yates and Gard* case para 16; see also the *Hollie Dance* case 1435.

31 See Auckland and Goold 2019 *CLJ* 291 with reference to the *Yates and Gard* case.

Central to this quandary is who should have the final say over the withdrawal of life sustaining treatment? That, necessitates an investigation into the general principles surrounding the conventional consent by the parents and alternative decision-making inter alia by the medical team and/or the courts.

3 Consent to medical treatment involving minor patients

3.1 The South African position

In terms of the South African common law, a medical practitioner may not provide medical treatment without first obtaining the consent of a competent patient.

Minor children, provided they meet the legislative requirements, do have the capacity to unilaterally consent to medical treatment and surgery without the parents' consent. To this end, the *Children's Act* 38 of 2005 (hereinafter referred to as "the Act") provides that –

> if the child is over the age of 12 years; and the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.[32]
>
> if the child is over the age of 12 years; and the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; the child is duly assisted by his or her parent or guardian treatment.[33]

In any of the categories involving minor children over the age of 12 years, where the child either lacks sufficient maturity or mental capacity, the child will be duly assisted by his or her parent or guardian.[34]

The Act also regulates consent to medical treatment and surgical operations in the following circumstances where the child has not attained the age of 12 years in age. In this regard, the Act determines:

> The parent, guardian or care-giver of a child may, subject to Section 31 of the Act, consent to medical treatment of the child if the child is under the age of 12 years; or over the age of but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.[35]

The parent, guardian or care-giver of a child may, subject to section 31, consent to a surgical operation on the child if the child is under the age of 12 years; or over that age, but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the operation.[36]

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32 Section 129(2)(a) and (b) of the *Children's Act* 38 of 2005 (the Act).
33 Section 129(3)(a), (b) and (c) of the Act.
34 Section 129(3) of the Act.
35 Section 129(4) of the Act.
36 Section 129(5) of the Act.

All medical decisions taken on behalf of minors should be made in the best interests.[37] A High Court or Children's Court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent, refuses or is unable to give such consent.[38]

The Act also regulates that parents may not as a general rule refuse to assist a child or withdraw consent for religious or other beliefs. In this regard the Act provides:

> No parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsections (4) and (5) by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.[39]

3.2 The English position

The age of majority in England and Wales is 18 years.[40] Section 8 of the *Family Reform Act* places 16 to 18 year- olds in a special position in that they are able to give consent to medical treatment as if they were adult.[41] But, they do not have the power by refusing treatment to override a consent given by the court or by a person having parental responsibility.[42] There is also another category of children known as "Gillick" competent children. This category refers to a young person under 16 with the capacity to consent to his or her own treatment without them needing parental permission. But the child is required to possess sufficient competence, maturity and understanding and capable of making decisions about their own health and medical treatment. The treatment must also be relatively risk-free.[43] Legislatively, section 1 of the English *Children Act* provides that when a court determines any question with respect to the upbringing of a child, the child's welfare is the paramount consideration.[44] Section 3 of the *Children Act* provides for parental responsibility, for as long as the parents serve the best interests of the minor patient.[45] Section 8(1) of the *Children Act*[46] provides the courts with jurisdiction in regard to the exercise of parental responsibility that concerns the child's best interests. The legislation is not explicit whether the two sections mentioned hereinbefore apply to medical

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37 Section 9 of the Act provides that in all matters concerning the care, protection and well-being of a child is in the child's best interest and of paramount importance.
38 Section 129(9) of the Act.
39 See s 129(10) of the Act
40 Section 1(1) of the *Family Reform Act*, 1969.
41 Section 8 of the *Family Reform Act*, 1969.
42 Oates 2000 *BMJ* 1282.
43 Oates 2000 *BMJ* 1282 with reference to the case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. See also the *Haastrup* case para 69.
44 See s 1 of the *Children Act*, 1989.
45 See s 3 of the *Children Act*, 1989.
46 See s 8(1) of the *Children Act*, 1989.

treatment, operations, withdrawal of the medical treatment etc. But, the England and Wales Court of Appeal in *Fixsler v Manchester University NHS Foundation Trust*[47] found that in terms of its inherent jurisdiction the court may authorise medical treatment where it serves the child's best interests. This principle may be used interchangeably with the welfare concept. Any interested person or the treating medical team may approach the High Court where, for example, a party unfairly refuses to consent to the withdrawal of end-of-life decision making.[48]

The United Kingdom, similarly, in terms of its common law allows parents to make decisions for their children in respect of medical care, including giving or withdrawing consent to medical treatment affecting their minor child.[49] Where the parents refuse to consent to treatment recommended by the medical practitioners, it may be necessary for them to approach the court to supply its consent through an order of court.[50] Legislatively, the English *Children Act*[51] provides for parental responsibility, for as long as the parents serve the best interests of the minor patient.[52] If that cannot be achieved, any interested person or the treating medical practitioners may approach the High Court where, for example, a party unfairly refuse to consent.[53]

The court in turn, may then use its inherent jurisdiction when making the all-important discretionary decision which runs counter to the decision of the consenting party.[54] In the so-called "life-saving" cases, including the blood transfusion cases, the British courts have always taken the view that they have the authority to make medical decisions on behalf of children.[55]

The next section of this article investigates when the courts' interventions are justified.

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47 The *Fixsler* case with reference to *Re Pippa Knight* [2021] EWCA Civ 362 (19 March 2021) para 69. See also *Barts NHS Foundation Trust and Raqeeb* [2019] EWHC 2530 (Fam).

48 Oates 2000 *BMJ* 1282 and the *Fixsler* case para 22.

49 Oates 2000 *BMJ* 1282; Auckland and Goold 2019 *CLJ* 287; see the English seminal case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 per Lord Scarman 184 (hereafter the *Gillick* case).

50 Oates 2000 *BMJ* 1282; Auckland and Goold 2019 *CLJ* 288.

51 See s 3 of the *Children Act*, 1989.

52 Oates 2000 *BMJ* 1282 and the *Fixsler* case para 34.

53 Oates 2000 *BMJ* 1282 and the *Fixsler* case para 34.

54 See *Re L* [1998] 2 FLR 810; *Birmingham Children's NHS Trust v B & C* [2014] EWHC 531 (Fam).

55 See the *Gillick* case 184; see also *R v A (Children)* [2001] 1 Fam 147 (HC).

4 The legal framework when a High Court will intervene

4.1 The South African position

The South African High Court owes its inherent jurisdictional authority to the English law influence most apparent in procedural law.[56] The eminent writer Pollak[57] describes the rationale for its existence as, "to ensure substantial justice is not denied". The font of the High Courts' authority has been our common law power as "upper guardian" of minors.[58] Besides the High Court exercising its role as upper guardian of minors, it also enjoys unwritten powers, often referred to as inherent jurisdiction. With the advent of the new *Constitution* the inherent jurisdiction of the courts has now been subsumed under section 173 of the *Constitution*.[59] That, the High Court exercises ancillary to its common law and statutory law powers.[60] High Courts can thus legitimately interfere with the decision-making authority of the parents[61] where there is a danger to children's lives, health and morals.[62]

Alongside the High Courts having the inherent authority to interfere with the decision-making authority of the parents as aforesaid, various other people and institutions by virtue of their legislative authority may also as surrogate decision-makers, intervene in the decision-making process affecting minor children.

The Superintendent of the hospital or his deputy in his absence may consent to medical treatment of or a surgical operation on a child if the treatment or operation will preserve life or prevent serious or lasting physical injury or disability; and the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent.[63]

The Minister may consent to the medical treatment of or surgical operation on a child if the parent or guardian of the child unreasonably refuses to give consent or to assist the child in giving consent or is incapable of giving consent or of assisting the child in giving consent or cannot readily be traced or is deceased.[64]

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56 Lutchman 2018 https://www.nyulawglobal.org/globalex/South_Africa1.html with reference to Meintjes-Van der Walt *et al Introduction to South African Law* 31 at [1] and [35]. See *Ritchie v Andrews* (1881-1882) 2 EDL 254; *Conolly v Ferguson* 1909 TS 195; *Ex Parte Millsite Investments Co (Pty) Ltd* 1965 2 SA 582 (T) 585 G-H.

57 Pollak *South African Law of Jurisdiction* 28.

58 See *Oosthuizen v Road Accident Fund* 2011 6 SA 31 (SCA) para 15; *Calitz v Calitz* 1939 AD 56.

59 See *Oosthuizen v Road Accident Fund* 2011 6 SA 31 (SCA) para 15.

60 Taitz *Inherent Jurisdiction of the Supreme Court* 8.

61 Van Heerden, Cockrell and Keighly *Boberg's Law of Persons and the Family* 500.

62 See *Calitz v Calitz* 1939 AD 56 63.

63 See s 129(6)(a) and (b) of the Act.

64 See s 129(7) of the Act.

The Minister may also consent to the medical treatment of a surgical operation if the child unreasonably refuses to give consent.[65]

4.2 The English position

The legal framework for the High Court's power to intervene in disputes involving minor children has its roots in the English common law *parens patriae* doctrine and founded on the principle of welfarism.[66] The court in *Re McGrath (Infants)*[67] first recognised the concept "welfare" by giving it the widest sense, including "the moral and religious welfare of the child, as well as its physical well-being".

More recently, in the case of *Re T (A Minor) (Wardship: Medical Treatment)*[68] the court reaffirmed its authority to intervene "whenever the child's best interests will otherwise not be promoted". But, the English courts have cautioned that courts should not usurp the function and power of parents, provided the parents act in the best interests of their children.[69] If not, interference is warranted.[70]

What follows is an investigation into the common law concept of "upper guardian", and when the High Court may act as upper guardian.

5 The High Court as upper guardian of minor children

5.1 The South African position

The legitimacy of our High Court to exercise its authority as an upper guardian and in the best interests of minor children, as seen earlier, stems from its inherent common law jurisdiction.[71] Spiro[72] equates the High Court's functionary role to act as the upper guardian of all minors with that of the State. Because courts are functionaries of the State they are vested with the necessary authority to interfere with parental rights and responsibilities where, circumstances threaten children's lives, health, morals and

65 See s 129(8) of the Act.

66 Laurie 1999 *Edin LR* 95 cited by Auckland and Goold 2019 *CLJ* 293.

67 *Re McGrath (Infants)* [1893] 1 Ch 143 148 (hereafter the *McGrath* case).

68 *Re T (A Minor) (Wardship: Medical Treatment* [1997] 1 WLR 242 (hereafter the *Wardship: Medical Treatment* case); see also *J v C* [1970] AC 668 710-711 (hereafter the *J v C* case) in which the paramountcy of best interests and the courts involvement was emphasised.

69 See the *Gillick* case 184.

70 See *In Re A (Children) (Conjoined Twins: Surgical Separation)* [2001] Fam 178 (AC)178-179; the position was endorsed in the *Fixsler* case para 87.

71 Van Heerden, Cockrell and Keighly *Boberg's Law of Persons and the Family* 500; Van Schalkwyk *General Principles of the Family Law* 311; see also the case of *Kotze v Santam Insurance Ltd* 1994 1 SA 237 (C) 244F-H.

72 Spiro *Law of Parent and Child* 257.

welfare.[73] The High Court's powers are, however, not unlimited. The High Court cannot interfere with a decision of the parent because it does not like it - there must be a legal justification.[74] In the so-called "blood transfusion cases" involving minor children, the High Court has shown its willingness to step in and grant appropriate orders, very much against the wishes of the parents. In *Hay v B,*[75] a paediatrician, had applied to the High Court for an urgent order allowing her to give a life-saving blood transfusion to a baby after the parents had refused to consent to the blood transfusion on religious grounds and because they feared the risks of infection associated with blood transfusions. Dr Hay, the medical practitioner, stated that there was no guarantee that the baby would survive if the child did not receive a blood transfusion. The High Court held that as the upper guardian of all minors, it had had to act in its "best interests". The High Court also found that "while the parents' religious beliefs had to be respected, and their concerns were understandable, they were not reasonable and justifiable and could not override the baby's right to life".[76] That, now seems to be fairly settled law in South Africa.[77]

Besides the case law, legislatively, the *Children's Act* also limits the parental, guardian or care-givers' rights to withhold consent "by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment concerned".[78]

5.2 The English position

The practice of the High Court acting as upper guardian of minor children in medical treatment is a phenomenon known in English law in both the so-called "Jehovah's Witness" cases as well as the so-called "end-of-life treatment" matters.[79] In the former, the parents, because of their religious beliefs, withhold their consent to blood transfusions with children's lives being endangered. Consequently, the treating practitioners will feel obliged

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73 The best interest-standard was first limited to private law disputes pertaining to custody, guardianship or access; see *Fletcher v Fletcher* 1948 1 SA 130 (A) 134 (hereafter the *Fletcher* case). See however Davel "General Principles" 2-6 who asserts that the application has been extended beyond the realm of private law.

74 SALC *Report on Access to Minor Children* para 2.18, with reference to *S v L* 1992 3 SA 713 (E).

75 See the *Hay* case 492.

76 See the *Hay* case 494-495 and the comments of McQuoid-Mason 2005 *SAMJ* 29-30; see also the case of *TC v SC* 2018 4 SA 530 (WCC) paras 44-45 in which the principles of the *Hay* judgment were approved.

77 See the *Hay* case 494-495 and the comments of McQuoid-Mason 2005 *SAMJ* 29-30; see also the case of *TC v SC* 2018 4 SA 530 (WCC) paras 44-45 in which the principles of the *Hay* judgment were approved.

78 See s 129(4) and (5) of the Act and the application thereof in the *Life Health Care Group (Pty) Ltd* case 299.

79 Oates 2000 *BMJ* 1284.

to approach the courts to safeguard the welfare of the minor patients.[80] They, then rely on the upper guardianship of the courts to provide the missing consent.[81] The English High Courts have frequently intervened by exercising their independent and objective judgment in the child's best interests and ruled against the parents.[82]

Because the concept "best interests of the child" in the latter category has been quite elusive in South Africa, the meaning will be explored in both the South African and English law.

6 The "best interests" of the child as a threshold in medical disputes in South Africa and England

6.1 The South African position

The "best interest" rule has for decades featured predominantly in custody matters involving minor children.[83] The rule is aimed at protecting children's physical, moral, emotional and spiritual welfare.[84] Our High Court has very wide powers when deciding what those interests are and each case is decided on its own facts.[85]

In medical cases involving blood transfusions, the High Court has relied on "the interests of the minor child" to prevent the child from dying and so oust parental authority where parents, by reason of religious beliefs, refused to consent to the transfusion.[86] The court relied on our common law and especially section 28(2) of the *Constitution*[87] as being paramount in

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80 Oates 2000 *BMJ* 1283 with reference to the cases of *Re F* [1990] 2 AC 56 and *Airedale NHS Trust v Bland* [1993] AC 789 859F.

81 Oates 2000 *BMJ* 1284 with reference to the cases of *Re R (A Minor) (Blood Transfusion)* [1993] 2 FLR 757*;* see also *Re S (A Minor) (Medical Treatment)* [1993] 1 FLR 149.

82 See the *Yates and Gard* case para 36 with reference to the *Conjoined Twins* case 480; the *Fixsler* case para 87; also the *Hollie Dance* case 1435.

83 See the *Fletcher* case 130; see also *McCall v McCall* 1994 3 SA 201 (C).

84 See *Kotze v Kotze* 2003 3 SA 628 (T) and endorsed by the Constitutional Court in *Mpofu v Minister of Justice and Constitutional Development* 2013 9 BCLR 107 (CC) para 21 (hereafter the *Mpofu* case).

85 See *Kotze v Kotze* 2003 3 SA 628 (T) and endorsed by the Constitutional Court in the *Mpofu* case para 21.

86 See the *Hay* case 492. In the most recent unreported case, *In Re Dr Nxolo Mbadi on behalf the Minor*, a Durban Jehovah's Witness couple refused to allow their chronically ill son to have a blood transfusion because of religious reasons. They relied on an alternate medical approach. Their refusal to consent to their 5-year-old who suffers from sickle cell anaemia be given the blood transfusion, was opposed by the KZN Health MEC. Dr Noxo Mbadi, the head of Paediatrics at the Addington Hospital, who supported the MEC's application, opined *inter alia* that if the child did not receive blood transfusion, he could suffer a stroke or die. It is reported that an order was apparently granted by Judge Graham Lopes for the minor to receive blood transfusion.

87 Section 28(2) of the *Constitution*.

preventing parents from withholding consent to treatment solely on religious grounds.[88]

Similarly, the High Court also relied on the *Children's Act*[89] to conclude that, it would be in the minor child's best interests to undergo the blood transfusion.[90] The court suggested that when weighing up the parents' right to freedom of religion and the child's right to life, the best interests of the child must inform the decision.[91]

6.2 The English position

The "best interests of the child" as seen herein before, is a concept that originated in the English law under the prism of welfarism.[92] The English courts have over centuries protected the physical and moral welfare of minor children.[93] But, despite recognising children's interests, the courts also have regards to parental authority, especially when exercising their right to consent.[94] Where, however, parents fail to protect the best interests of their children in medical care, the High Court, using its overriding authority, will step in to protect the minor children. The child's "best interests" dictate that it was the court that had the final say.[95] Instances where this occurred include where the parents' decisions are filled with factual errors or bias towards their children, which, conflicts intractably with that of the medical practitioners.[96]

What has, however, not escaped criticism is the High Court's overriding authority that has at times found to be too wide.[97] What is advocated is that the parent(s) of the child affected, knows what is best for the child patients and should, therefore, have a greater say in the end-of-life decision-making.[98] What is also advocated is that adequate weight should be given

88 See the *Hay* case 494-495.
89 Section 129(10) of the Act provides that no parent may withhold consent for medical treatment of a child by reason only of religious or other beliefs, unless the parent can show that there is a medically acceptable alternative choice to medical treatment.
90 See the *Life Health Care Group (Pty) Ltd* case para 10.
91 See the *Life Health Care Group (Pty) Ltd* case para 10.
92 Auckland and Goold 2019 *CLJ* 294.
93 See the *McGrath* case 148.
94 See the *J v C* case 710 and *the Wardship: Medical Treatment* case 242; see also the *Gillick* case 184.
95 *Portsmouth Hospitals NHS Trust v Wyatt* [2005] EWCA Civ 1181 (hereafter the *Wyatt* case).
96 See Auckland and Goold 2019 *CLJ* 302-303 with reference to the *Haastrup* case para 58; See also *Yates and Gard* case para 39 and the *Hollie Dance* case para 165.
97 Auckland and Goold 2019 *CLJ* 296.
98 Auckland and Goold 2019 *CLJ* 296.

to the generational values and beliefs passed on in families which include religion, culture and family considerations.[99]

The so-called "blood transfusion" cases appear to be fairly settled in South Africa. What is called for, is the development of our legal jurisprudence in the end-of-life cases. This aspect will be further explored in this paper.

7 The legal position regarding the withholding and withdrawal of life support treatment in South Africa

7.1 The South African position

The withholding and withdrawal of life support are two processes by which various medical interventions either are refused or are ceased with the understanding that the patient will die as a result.

The withholding of life sustaining treatment has been defined as "processes by which medical interventions are refused or denied being provided often with the understanding that the patient will most probably experience natural death from the underlying disease or related complications".[100] Withholding life-sustaining treatment entails a decision that is made by a medical team not to start or increase a life-sustaining intervention.[101] On the other hand, the withdrawal of life sustaining treatment has been defined as "processes by which medical interventions are ceased or discontinued often with the understanding that the patient will most probably experience natural death from the underlying disease or related complications".[102] Decisions to withdraw life-sustaining treatments may be taken by the treating medical team where the circumstances warrant the ceasing of further treatment, especially where they believe the continued treatment will be futile. Although an understanding of both processes is of great importance, the focus of this article primarily centres on the withdrawal of life support treatment or end-or-life decision making.

South African courts, unlike their English counterparts are not as resourceful in handling the so-called withdrawal of life support or end-of-life decision making. The only case featuring the court authorising the discontinuance of nasogastric feeding is that of *Clarke v Hurst*[103] which was decided three decades ago. In that case, an adult patient, a medical doctor, suffered a

99 Auckland and Goold 2019 *CLJ* 323 with reference to *Re King* [2014] EWHC 264 (Fam).

100 HPCSA 2023 https://www.hpcsa.co.za/Uploads/professional_practice/ethics/Booklet_7-Guidelines_withholding_andwithdrawing_treatment_FINAL_%20March2023.pdf (HPCSA *Booklet 7*) 1.

101 Gasa 2020 Gasa 2020 https://anaesthetics.ukzn.ac.za/wp-content/uploads/2020/10/04-September-2020-Palliative-Care-Medicine-EOLC-M-Gasa.pdf 7.

102 HPCSA *Booklet 7* 1.

103 *Clarke v Hurst* 1992 4 SA 630 (D) (hereafter the *Clarke* case).

cardiac arrest which led to him to sustain irreversible brain damages. Consequently, to stay alive he had to be fed through a nasogastric tube for five years.

The High Court, however, found that the discontinuance of an artificial feeding regime, would not be "the legal cause of the patient's death"[104] and would not be unlawful.[105] Nor would it offend the legal convictions of society.[106] The court found that it would be in the patient's best interests to permit him to die.

Despite the outcome of the case, the *Clarke* case cannot be equated with cases falling within the category of those forming the focus of this article. It is, therefore, uncertain what approach the South African courts is likely to adopt in respect of the withdrawal of life support or end-of-life decisions, including those affecting minor children.

The Health Professions Council of South Africa has recently introduced guidelines to provide an ethical framework of good practice for healthcare practitioners in respect of "end-to-life decision-making" affecting *inter alia* adult and child patients. This includes making decisions on whether to withdraw life-prolonging treatment.[107] A striking feature of the guidelines includes the strong emphasis placed on "the best interests of the patient" principle.[108]

The guidelines recognise that where decisions are taken that do not serve the child's best interests, the High Court or the Children's Court may be approached to resolve the issue. No clear guidelines have, however, been formulated on how our courts should approach end-to-life decision-making.[109] It does. however, appear that the South African courts are likely to adopt an orthodox approach, commencing with the "best interests of the child", followed by the "High Court's 'upper guardian'" doctrine. They are well-recognised concepts and rights in terms of the South African *Constitution*,[110] the *Children's Act*[111] and the common law through the courts.[112]

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104 *Clarke* case 660B-C.
105 *Clarke* case 660D-F.
106 *Clarke* case 657.
107 HPCSA *Booklet 7* 2.
108 HPCSA *Booklet 7* 2, 4, 7, 8, 9, 12.
109 HPCSA *Booklet 7* 12.
110 Section 28(2) of the *Constitution* provides that "a child's interests are of paramount importance in every matter concerning the child".
111 Section 9 of the Act provides that "in all matters concerning the 'care, protection and well-being of a child', the standard that the child's best interests is of paramount importance must be applied".
112 See the *Mpofu* case 107 in which the Constitutional Court confirmed that the High Court is the upper guardian in matters involving the best interests of the child.

7.2 The English position

The English legal cases are replete with tragic end-of-life decision-making cases involving children born in England with congenital conditions[113] and those, born with no abnormalities but develop conditions due to unexpected natural events.[114] End-of-life decision-making in this regard include where a decision has to be taken to end or not to end a patient's life in circumstances where his or her life is limited both in quality and quantity to such extent that there is no reasonable prospect for recovery. No benefit will, therefore, be derived from continued life.[115] The general approach of the English courts seems to be the following, although the courts recognise the parental responsibilities, the overriding control seems to be vested in the courts exercising their independent and objective judgment as upper guardian of minor children in the "child's best interest".[116]

The English legal system has developed a rich jurisprudence in those courts, handling these cases, including a uniform approach when adjudicating these matters.[117] Some of the salient principles will be dealt with hereinafter.

7.3 The approach by the English courts when considering the withdrawal of life sustaining treatment

When courts in England consider the withdrawal of life sustaining treatment of minor patients, the courts assess the position by weighing up different factors, including legal principles. One of the primary considerations the courts entertain is the medical condition of the patient, for example, whether he or she is "brain dead",[118] the child suffers a "severe hypoxic ischaemic brain injury" at birth[119] and a child develops a blood clot on the brain with consequential irreversible damages.[120] Other considerations include *inter alia* the patients' consciousness, their symptoms with regard to pain and movement and whether the symptoms are going to worsen.[121] The medical condition of the patient is a major determinant in ascertaining whether the patient has the necessary capacity to consent. It also serves as part of the legal framework to determine whether children are "Gillick" competent or

113 See the *Fixsler* case para 1; also the *Haastrup* case.
114 See the *Raqeeb* case; also the *Hollie Dance* case 1435.
115 See the *Yates and Gard* case para 60 with reference to the RCPCH 2015 https://issuu.com/joballrcpch/docs/rcpch_annual_review15web3 to withdraw life sustaining treatment.
116 See the *Yates and Gard* case para 11.
117 See the *Fixsler* case 1018.
118 See the *Hollie Dance* case.
119 See the *Fixsler* case.
120 See *Barts NHS Foundation Trust v Raqeeb* [2019] EWHC 2530 (Fam) (3 October 2019).
121 See the *Fixsler* case.

not.[122] Where minors are not "Gillick" competent, the views of the natural parents or care givers who are legally empowered to consent on behalf of their children's welfare are of great importance.[123] Where there is a dispute between the parents and the clinicians about the withdrawal of life support treatment or end-of-life decisions, the courts have held that while the views and wishes of the parents will always carry weight, the final decision rest with the court to decide what is in the child's best interests.[124] Whether it is in the patient's best interests to give the treatment rather than whether it is in their best interests to withdraw it, if the continued treatment is not in the patients' best interests the court will not consent to it. It follows that it will be lawful to withhold or withdraw the treatment.[125] The courts have also made it clear that where decisions are made that adversely affect minor children, they may be interfered with.[126] Here, if the circumstances so dictate, the courts may override the decision of the parents. This may include parents refusing to consent to the withdrawal of life-support treatment, regarded by the treating clinicians as adverse to the interest of the patients.[127]

It is worth noting that the courts have on occasions found in favour of the parents, especially where their aim is to serve the best interest of the children.[128] But, the courts have also found against the parents, notwithstanding their best motives where their decisions run counter to the best interest of the children.[129] The courts have also at times, expressed their difficulties in making those decisions.[130]

Consequently, some of the main principles that influence the decision-making process of the English courts, will be investigated.

7.3.1 Legal capacity of the minor

Where a child is capable of consenting it should be accepted especially in the light of his or her age and understanding.[131] Where the child is unable to consent, the parent(s), by reason of his or her parental responsibilities in terms of the common law and the *Children's Act*, 1989, will provide consent

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[122] See the *Haastrup* case para 69 with reference to *inter alia* the cases of *Wyatt v Portsmouth NHS Trust* [2006] 1 FLR 554; *Yates and Gard v Great Ormond Street Hospital for Children NHS Foundation Trust* [2017] EWCA Civ 410.

[123] See the *Fixsler* case para 87.

[124] See the *Fixsler* case para 87.

[125] See the *Raqeeb* case para 117.

[126] *Alder Hey Children's NHS Foundations Trust v Evans* [2018] EWLA Civ 805 (hereafter the *Evans* case).

[127] See the *Fixsler* case 1018; the *Hollie Dance* case 1435.

[128] *In Re Z (Identification: Restrictions on Publication)* [1997] Fam 1.

[129] See the *Hollie Dance* case 1435; see also the *Fixsler* case 1018 with reference to the *Yates and Gard* case para 112.

[130] See the *Yates and Gard* case para 2 of the judgment.

[131] See the *Haastrup* case para 115 of the judgment.

for the child to undergo treatment.[132] It involves the promotion of the welfare of the child.[133] The parental responsibility is, however, not unfettered.[134] Where the welfare of the child is not realised for example, the parent(s) refuses to consent to the withdrawal of medical treatment contrary to the interest of the child, the High Court is empowered by virtue of its inherent jurisdiction to make an opposing decision that is in the best interest of the minor patient.[135]

7.3.2 Parental responsibility and the upper guardianship of the courts

The High Court acknowledges parental responsibility in relation to the minor child.[136] But, the court is also mindful that, given the bond between the parent and child, the view of the parent may be filled with love and devotion for the child, coloured by a lot of emotion.[137] Because of the parent's subjective state of mind his or her decision-making rights may be interfered with by the courts, especially where for example the parent is not acting in accordance with the welfare of the child and contrary to the medical practitioners' medical opinion, supported by medical evidence.[138] Where that leads to an unresolved dispute between them,[139] the courts as upper guardian of minors will step in and resolve the dispute even if it means withdrawing the life-support treatment.[140]

7.3.3 The jurisdiction of the court to make orders

The High Court's jurisdiction to make orders authorising the withdrawal of medical treatment from minor children has been summarised by the courts as follows, where the child cannot make the choice it then has to be made by the parents, caregivers or the courts on behalf of children, serving their best interests.[141] While the views of the parents remain of great importance to the courts when the unresolved dispute between parents and clinicians

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132 This is sometimes referred to as the Gillick rule, emanating from the judgment of the *Gillick* case 184 per Lord Scarman.

133 See the *Raqeeb* case para 102 of the judgment.

134 The *Raqeeb* case with reference to the *Evans* case 805.

135 See the *Yates and Gard* case para 36 with reference to *Conjoined Twins* case 480.

136 The *J v C* case 710-711 and *the Wardship: Medical Treatment* case; see the *Gillick* case 184; also the *Yates* case 942.

137 See the *Haastrup* case para 69 with reference to *An NHS Trust v MB (A Child Represented by CAFCASS as Guardian ad Litem)* [2006] 2 FLR 319 quoting *Re A (A Child)* [2016] EWCA Civ 759.

138 See the *Haastrup* case para 69 with reference to *An NHS Trust v MB (A Child Represented by CAFCASS as Guardian ad Litem)* [2006] 2 FLR 319 quoting *Re A (A Child)* [2016] EWCA Civ 759.

139 See the *Raqeeb* case para 103 with reference to the *Wardship: Medical Treatment* case.

140 See the *Fixsler* case para 87.

141 The *Fixsler* case para 87.

are brought before the court, it is then for the judge to decide what is in the child's best interests.[142]

7.3.4 Assessment of the child's medical condition

The child's medical condition and prognosis serve as a profound influencing factor when the court weighs up *inter alia* the best interest of the child and whether or not it will issue an order for the life-support system to be withdrawn.[143] In making that decision, the court will rely heavily on the opinions of expert witnesses.[144] The child patient's current medical condition and whether the poor condition is irreversible or not is cardinal to the court's decision-making outcome.[145] Also, whether the patient will continue to suffer pain and discomfort.[146] But, judges have also held that they are not bound to follow the clinical assessment of the experts.[147] They follow their own independent assessments, especially the welfare factors that inform the child's best interests.[148]

7.3.5 The best interest and welfare of the minor child

The best interest and welfare approach have been relied on by the courts for a number of decades.[149] Judges, when making end-of-life decisions involving minors, appear to adopt the widest possible approach.[150] The term "best interests" encompasses medical, emotional, and all other welfare issues, including sensory (pleasure, pain and suffering) and instinctive (human instinct to survive).[151] The human instinct to survive has given rise to the prolongation of life principle.[152] This belief is heavily influenced by promoting the sustaining of human life.[153] But, the prolongation of life is not absolute nor decisive, and may sometimes have to give way to countervailing factors such as the severity of the child's underlying medical condition and inability to enjoy the benefits of life.[154] Another issue for

142 See the *Fixsler* case para 14 with reference to the *Wyatt* case.
143 See the *Raqeeb* case paras 19, 31.
144 See the *Fixsler* case paras 36-40.
145 See the *Raqeeb* case para 31.
146 See the *Raqeeb* case paras 163-164 of the judgment; see also the *Fixsler* case paras 1-6.
147 See the *Raqeeb* case para 1 and para 116 with reference to *inter alia* the *Wyatt* case.
148 See the *Raqeeb* case para 116 with reference to the *Wardship: Medical Treatment* case 906.
149 See the *Fixsler* case para 87; see also the *Wyatt* case page 554; the *Yates and Gard* case para 13.
150 *An NHS Trust v MB (A Child Represented by CAFCASS as Guardian ad Litem* [2006] 2 FLR 319 (hereafter the *CAFCASS* case).
151 See the *Yates* case 942; see also the *CAFCASS* case 319.
152 See the Y*ates* case para 39 with reference to the *Wyatt* case 554.
153 See the *Raqeeb* case para 7; the *Fixsler* case para 42; also the *Wyatt* case 554.
154 See the *Yates* case para 39 with reference to the *Wardship: Medical Treatment* case para 46.

consideration is the worth that child-life brings to the parents, siblings and the collective family.[155]

For the courts to satisfy the best interests of the patient test, Judges often embark on a balancing exercise by weighing up every kind of consideration capable of impacting on the decision. In reaching a decision the welfare of the child is paramount. Putting the child through more pain and suffering is not conducive to the child's best interests.[156] Brain stem death could also serve as criteria to determine whether the ventilator be removed.[157]

7.3.6 Weighing up the interests of the litigants

The courts have often stated that the views and opinions of both the doctors and the parents should be weighed up carefully.[158] This is very much influenced by the type of treatment proposed by the medical team and the lawfulness thereof.[159] The courts have in the past decided the patient's best interests in receiving the treatment should prevail over withholding or withdrawing it.[160] The ultimate prospect of improvement in the patient's condition is fundamental.[161] The greater the likelihood of the intensity of the pain and non-recovery, the less the weight to be given to keeping the patient alive.[162]

7.3.7 The assumed point of view of the child criteria

The so-called "substituted judgment test" has recently been designed to assist courts in making decisions for persons whose future medical treatment seems to be futile. Here, the Judge tries to place himself or herself in the position of the person lacking capacity and considers the matter from the “assumed point of view of the child'”by asking what the child's attitude to treatment would likely to be?[163] The difficulty the Judge faces is having to place themselves in the shoes of, for example a four-year old child and having to express an opinion.[164] The child is not a free thinker and their attitude would very much be influenced by the views, religious beliefs and

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155 See the *Fixsler* case 1018; also the *Hollie Dance* case para 165.

156 See the *Yates* case para 128 with reference to the *CAFCASS* case.

157 See the *Hollie Dance* case paras 153-154.

158 See the *CAFCASS* case 319 with reference to the *Yates* case paras 39, 165.

159 *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67 (hereafter the *Aintree* case) paras 19-21 referred to in the *Yates and Gard* case para 39.

160 See the *Aintree* case para 22; see also the *Yates and Gard* case para 38.

161 *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33 (CA) 46D-F referred to in the *Fixsler* case para 14.

162 See the *Yates and Gard* case 972; also the *Raqeeb* case 2531; the *Haastrup* case 177; the *Fixsler* case paras 62, 63.

163 *Re Pippa Knight* [2021] EWCA Civ 362 (19 March 2021) referred to in the *Fixsler* case para 11; see also the *Raqeeb* case para 122.

164 See the *Raqeeb* case para 122 and especially para 166; also the *Fixsler* case para 82.

guidance of their parents in promoting the sanctity of human life.[165] A very young child who sustained serious brain damage at birth could never learn anything about religion and culture. Nor does the child have any cognitive understanding.[166]

7.3.8 Consideration of mediation as a dispute resolution mechanism

Mediation has been described in England as a flexible, confidential process which involves a neutral third party helping the parties in dispute towards a negotiated resolution, where the parties have the final say as to whether agreement is reached and if so, on what terms.[167] The process is said to have various benefits, including open discussions that can be attempted at any stage of a dispute.[168] It enhances a greater understanding of the issues between the parents and the clinical team.[169] Where mediation does not resolve the dispute the matter may, provided the pleadings have been closed, be sent to the court where the litigation process will be pursued. Another benefit of mediation is that it is not as time consuming and costly as litigation.[170]

The English Courts have on a number of occasions in these end-of-life cases involving minor children ended the judgments with a procedural note, encouraging potential litigants in like matters to make use of mediation to resolve their disputes.[171] It has led to a number of cases been resolved through mediations in England.[172]

This article will also suggest that the nucleus of the approach adopted by the English courts, should be followed in South Africa.

8 The suggested approach of the South African courts when considering the withdrawal or withholding of medical treatment

The withdrawal, withholding or sustaining of life support treatment in the so-called end-of-life decision-making involving minor child patients in South Africa, has received very little attention.[173] A lack of clarity exists both from

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165 See the *Haastrup* case para 100; also *Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33 (CA) 46H-47B referred to in the *Fixsler* case para 15.

166 See the *Raqeeb* case para 166.

167 See Centre for Effective Dispute Resolution date unknown https://www.cedr.com/about_us/library/glossary.php.

168 See Wilkinson, Barclay and Savulescu 2018 *Lancet* 2302, 2304.

169 See the *Yates and Gard* case para 130.

170 Bierlein 2008 *Ohio St J on Disp Resol* 87 referred to in Van der Westhuizen 2015 *THRHR* 63.

171 See the *Yates and Gard* case para 130.

172 See the *Wyatt* case 4027.

173 Although the court in the *Hay* case on application, dealt with the administration of blood transfusion to a minor child, it did not have to deal with the sustaining of life

our case law as well as academic writings how our courts are likely to approach the withdrawal, withholding or sustaining of life-support treatment affecting especially minor children. That leaves the South African courts very much exposed when judges are called upon to preside over trials involving those type of matters. A likely starting point would be for judges to traverse the South African domestic law, including the Constitution, common law and customary law infusing African jurisprudence or indigenous knowledge.[174]

South Africa is a religious and culturally diverse country[175] where religion and culture play a fundamental role in especially the upbringing of children. The Bill of Rights in the South African *Constitution* recognise and protect both religious and cultural rights.[176] Those rights may be considered in end-of-life decision making. But, in what follows those rights do not trump the other constitutional rights. Those rights are not unfettered or unrestricted.[177] They may be limited by a law of general application, provided the limitation is reasonable and justifiable.[178] In one of the few cases involving the Constitution and medical treatment involving blood transfusion, the court found that the right to life was "the most basic constitutionally protected value" and "the preservation of life was held to be uppermost".[179] The court also accentuated the *Children's Act* to be a law of general application and the limitation it imposes on the parents' right to religion, is justified by section 36 of the *Constitution*.[180]

Factors that have received very little attention in South Africa but is worthy of scrutiny are the values and practices concerning death in the African society. Here, in terms of their religious and cultural beliefs life should be preserved by all means even if the case is a hopeless one.[181] The average African is believed not likely to discontinue life-sustaining treatment once it

support treatment nor the withdrawal thereof; In the *Clarke* case the court also on application, decided to order the discontinuance of an artificial regime. See also Van der Westhuizen 2015 *THRHR* 63-79 on the parents' decision-making involving critically ill neonates in intensive care units.

174 Manthwa 2023 *Obiter* 661, 662 with reference to the case of *Alexkor v Richtersveld Community* 2004 3 All SA 244 (LCC) para 51.

175 Moleya 2018 *De Rebus* 30.

176 See s 31 of ch 2 of the *Constitution*.

177 Currie and De Waal *Bill of Rights Handbook* 150.

178 Section 36 of the *Constitution*.

179 See the *Life Health Care Group (Pty) Ltd* case para 14 with reference to the case of *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) in which the court emphasises the paramountcy of the child's best interests. See McQuoid-Mason 2005 *SAMJ* 100 with reference to the *Hay* case.

180 See the *Life Health Care Group (Pty) Ltd* case para 15 of the judgement.

181 Ekore and Lanre-Abass 2016 *Indian Journal of Palliative Care* 371.

has commenced and also do not favour any artificial termination of life.[182] While every effort should be made to infuse customary law into dispute resolutions and judicial pronouncements,[183] that must be done against the backdrop of the South African *Constitution*.[184]

Other sources of law likely to enjoy judicial scrutiny include legislative enactments,[185] ethical practices[186] and specific guidelines.[187]

Judges may where necessary also draw on English law to develop the South African law in the so-called end-to-life decision making cases. The reason for involving English law is two-fold. First, it is the country with the greatest experience in end-to-life decision making. Second and most importantly, the English legal system lends itself to comparison with the South African legal system due to the common heritage of the two systems.[188]

Although foreign law is not binding on the South African courts, [189] the usefulness of considering foreign jurisprudence, has been recognised by the South African courts since 1994.[190] Besides the *Constitution* which permits the consideration of foreign law,[191] there are a number of South African cases involving health care law in which the courts sought guidance from foreign jurisdictions as well.[192] The courts emphasise the importance

182 Onukwugha date unkwnown https://www.nathanielturner.com/deathanddy ingafrican.htm referred to by Ekore and Lanre-Abass 2016 *Indian Journal of Palliative Care* 371.

183 Manthwa 2023 *Obiter* 661-662 with reference to the Constitutional Court case of *S v Makwanyane* 1995 3 SA 39 (CC).

184 Manthwa 2023 *Obiter* 666 with reference to s 211 of the *Constitution* provides that the recognition of African values of practices is subject to its consistency with the Bill of Rights.

185 The *Children's Act* 38 of 2005

186 HPCSA 2021 https://www.hpcsa-blogs.co.za/wp-content/uploads/2023/02/Booklet-1-General-ethical-guidelines-for-health-care-professions.pdf.

187 HPCSA *Booklet 7*.

188 The strong bond between the two legal systems in a socio-economic context is borne out by a number of cases involving health and medicine including *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* (531/2015) [2016] ZASCA 197 (6 December 2016) para [32] regarding an array of English cases. See also para [34] with regards to the *Clarke* case with reference to the English decision of *R v Adams* 1957 Crim LR 365; the *Hay* case with reference to the case of *In T (A Minor) (Wardship: Medical Treatment)* 1997 1 All ER 906 (CA); *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 1 SA 765 (CC) para [30] with regard to the English case of *R v Cambridge Health Authority* [1995] EWCA Civ 49.

189 Rautenbach, Van Rensburg and Pienaar 2003 *PELJ* 1-19.

190 Rautenbach 2015 *PELJ* 1546.

191 Section 39(1)(c) of the *Constitution* provides that "when interpreting the Bill of Rights, a court, tribunal or forum- may consider foreign law"; see also s 173 that promotes the development of the common law where it is in the interests of justice and within the "spirit, purport and objects" of the Bill of Rights.

192 *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 1 SA 765 (CC) (hereafter the *Soobramoney* case); also *Castell v De Greef* 1994 4 SA 408 (C) 419-423.

of adopting the foundational principles of foreign law to suit the needs of the South African jurisprudence in developing its common law.[193] To this end, English law has had a profound effect on South African law both in respect of procedural law as well as adjudicative practices in courts.[194]

It is suggested that when any of the South African courts find difficulty in dealing with end-of-life decisions involving minor children in future, the court dealing with the matter may likely consider adopting the criteria crafted in paragraphs 7.3.1 to 7.3.8 above. Because mediation is a fairly new form of dispute resolution in South Africa, this article suggests that we follow the practice displayed in England where the parties to the dispute first attempt mediation before resorting to litigation.

It is for that reason that this article suggests that both health care practitioners and Judges alike, acquire a greater knowledge and understanding of the religious and cultural beliefs, needs and practices of those affected patients. For the former, it may mean integrating their awareness into the treatment planning and care,[195] for judges, it could mean sensitivity training and the application thereof when considering the sustaining, withholding or withdrawal of healthcare treatment.

This article also suggests that before the High Court's inherent authority trumps parental authority, the court should first have substantial regard to the following factors, namely the emotional, religious, cultural and family in the parent-child relationship.

9 Conclusion

Resolving disputes between parents of minor patients and the treating medical team regarding end-of-life decisions affecting the patients, will always be arduous. Where possible, mediation should first be attempted to resolve the dispute between the parties, before they resort to litigation. Where they cannot, it would then be left to the court to intervene and make the correct decision. The parents may object on moral, cultural and religious grounds to consent to the withdrawal of life-support treatment suggested by the treating medical team. The treating clinicians on the other hand, may argue that the parents' refusal is not in the best interests of the child patient. Any further treatment they may argue, would be futile. The task of the courts is then to decide whether life sustaining treatment should be discontinued or not. The South African courts, unlike their English counterparts, have not been exposed to the so-called end-to-life cases. There is thus a lot of uncertainty how the courts are likely to approach this contentious issue. It may very well be necessary and in public interests to develop our

193 The *Soobramoney* case; also *Castell v De Greef* 1994 4 SA 408 (C) 419-423.
194 Du Bois and Bradfield *Wille's Principles of South African Law* 115.
195 Rumun 2014 *International Journal of Education and Research* 47.

jurisprudence along the lines of the English court decisions. Our courts should, however, have substantial regard to the following factors, namely the emotional, religious, cultural and family in the parent-child relationship. Both our common law as well as our *Constitution* supports such a move.

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List of Abbreviations

BMJ	British Medical Journal
CLJ	Cambridge Law Journal
DNA	deoxyribonucleic acid
Edin LR	Edinburgh Law Review
HPCSA	Health Professions Council of South Africa
MDDS	Mitochondrial DNA Depletion Syndrome
Ohio St J on Disp Resol	Ohio State Journal on Dispute Resolution
PELJ	Potchefstroom Electronic Law Journal
RCPCH	Royal College of Paediatrics and Child Health
SALC	South African Law Commission
SAMJ	South African Medical Journal
THRHR	Tydskrif vir Hedendaagse Romeins-Hollandse Reg