

Informed consent and access to gender-affirming treatment for children in South Africa

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SUMMARY

Informed consent for medical treatment is a developed legal concept in South African common law; the elements of which have been clearly set out by our courts. The overarching principle is viewed as a collaboration between medical practitioner and patient to understand the medical prognoses, medical advice and recommended treatment as well as the risk associated with such treatment. It should be done in such a way that the medical practitioner is not viewed as the “gatekeeper” of the medical treatment, but that the practitioner has confidence that they have provided the necessary information to enable the patient to decide. Where children are concerned, there is a greater duty to ensure informed consent for medical treatment is obtained in a manner that safeguards the short-term and long-term, best interests of the child, while also respecting the evolving capacities of the child. This paper examines the rights of children to consent to gender-affirming treatment and explores how this issue could be dealt with in an approach that recognises the autonomy of children while ensuring that their short-term and long-term best interests are upheld. The paper argues that the provisions of section 129 of the Children’s Act 38 of 2005 and the Gender Affirming Healthcare Guidelines provide sufficient guidance as to how informed consent for gender-reaffirming treatment for children should be obtained in line with their evolving capacities.

1 Introduction

In South Africa, section 129 of the Children’s Act 38 of 2005 specifically provides the framework for consent for- and by- minor children to medical treatment and distinguishes between consent for medical treatment and surgical operation.¹ The issue of informed consent in South African law intersects with several constitutional rights and obligations. These include the right to dignity, and privacy, to have access to information, to be free from torture, and cruel and inhumane treatment, the right to bodily autonomy and to make decisions about

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1 S 129 of the Children’s Act 38 of 2005.

one's body.² Importantly, informed consent also impacts the right to health and to access health care as entrenched in section 27 of the Constitution of the Republic of South Africa, 1996 (Constitution). On the other hand, the Constitution also requires that the best interests of the child be the primary consideration in every matter that concerns the child³ and this will also have to be a central feature of the decision pertaining to a child accessing gender-affirming treatment. Thus, there has to be an intentional and individualised approach in determining the outcome for a specific child, taking into consideration their evolving capacities⁴ as well as short-term and long-term best interests.⁵ This paper explores possible ways towards this balanced approach. In particular, the paper starts by setting out the concept of informed consent under common law and how the courts have interpreted this; it then looks at the applicable legislation such as the National Health Act⁶ with a focus on how it defines informed consent and provides guidance for how medical practitioners should understand this concept. Furthermore, it reflects on some case law pertaining to how the courts have interpreted informed consent to medical treatment by adults. Subsequently, the paper assesses how section 129 of the Children's Act read with the aforementioned laws and case law as well as the South African HIV Clinicians Society's Guidelines on Gender-affirming Healthcare in South Africa,⁷ should be understood in so far as children's consent to gender-affirming treatment is concerned. Furthermore, the paper advocates for a cautious approach, informed by the recent case from the United Kingdom where the courts had to grapple with whether children can consent to gender-affirming treatment.

2 Defining gender-affirming treatment

The World Health Organization defines gender-affirming care as encompassing a range of "social, psychological, behavioural, and medical interventions designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth.⁸ This condition, termed gender dysphoria is defined in the *Bell v*

2 Ss10, 12, and 14 of the Constitution of the Republic of South Africa, 1996.

3 S 28(2) of the Constitution.

4 See art 5 of the United Nations Convention on the Rights of the Child and General comment No 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4 available at <https://www.refworld.org/docid/4538834f0.html> (last accessed 2023-11-05).

5 In line with case law on the interpretation of s 28(2) of the Constitution such as *S v M (Centre for Child Law as Amicus Curiae)* 2008 3 SA 232 (CC); *Teddy Bear Clinic v Minister of Justice and Constitutional Development* 2014 2 SA 208 (CC); *AB v Pridwin Preparatory School* 2020 9 BCLR 1029 (CC).

6 61 Of 2003.

7 The South African HIV Clinicians Society Gender Affirming Health Care Guidelines. Available at https://sahivsoc.org/Files/SAHCS%20GAHC%20guidelines-expanded%20version_Oct%202021.pdf (last accessed 2023-10-15).

Tavistock case as “a condition where persons experience distress because of a mismatch between their perceived identity and their natal sex, that is, their sex at birth”.⁹ Such persons have a strong desire to live according to their perceived identity rather than their natal sex.¹⁰

The interventions help transgender people align various aspects of their lives – emotional, interpersonal, and biological – with their gender identity. As noted by the American Psychiatric Association (APA), identity can run anywhere along a continuum that includes man, woman, a combination of those, neither of those, and fluid.¹¹ The Association of America Medical Colleges (AAMC) indicates that these interventions fall along a continuum as well, from counselling to changes in social expression to medications (such as hormone therapy).¹² Intervention for children is based on several factors including “cognitive and psychical development as well as parental consent”.¹³ As articulated in AAMC, surgery is rarely provided for children below the age of 18, this includes the reduction of a person’s Adam’s apple or aligning their chest with the gender identity.¹⁴ One of the available hormone-related therapies according to the AAMC is “puberty blocker” which is a medication that transgender youths who have not started or completed puberty can receive. This medication suppresses sex hormones including testosterone and estrogen.¹⁵ The purpose of “puberty blockers is to allow a young person time to fully determine their gender identity and how far they wish to transition before the onset of permanent sex characteristics”.¹⁶ Accordingly, these may be useful and are usually used in early puberty to slow things down as the youth have not had much of an option to explore who they are, but have expressed that something not feeling right about their assigned gender.¹⁷ Puberty blockers are typically not initiated after a child finishes puberty, because they are not necessary and some of the blocked hormones are necessary for healthy adult development (such as estrogen for bone strength). It is argued that if puberty blockers are stopped during puberty, hormone development resumes until the end of that child’s puberty.¹⁸ There are current ongoing debates in relation to the suitability or not of gender-affirming treatment for children.¹⁹ In particular, there are questions pertaining to whether

8 See Association of America Medical Colleges “What is gender- affirming care? Your questions answered” <https://www.aamc.org/news/what-gender-affirming-care-your-questions-answered> (last accessed 2023-10).

9 See *Bell v Tavistock* [2020] EWHC 3274 para 3.

10 As above.

11 GAHC Guidelines (2021) 17.

12 See n 8 above.

13 See Association of America Medical Colleges “What is gender- affirming care? Your questions answered” <https://www.aamc.org/news/what-gender-affirming-care-your-questions-answered> (last accessed 2023-10).

14 As above.

15 As above.

16 As above.

17 As above.

18 As above.

19 As above.

children can consent to the treatment and whether they understand the short and long-term consequences thereof.²⁰

South Africa has also moved from the medicalised approach to diagnosing and treating gender dysphoria and is guided by the World Professional Association for Transgender Health's Standards of Care for Transsexual, Transgender and Gender-non-conforming People.²¹ The focus of this approach according to the GAHC Guidelines is to "provide clients with safe and effective pathways to achieving lasting personal comfort with their gender selves in order to maximise their overall health, well-being and self-fulfilment".²²

This paper explores the approaches to informed consent by children as well as parental consent in relation to gender-affirming treatment. The focus is on non-surgical medical treatment and not gender-affirming surgery as this is a much more complex issue best left for another day.

3 Overview informed consent to medical treatment in South Africa

3 1 General common law and constitutional law approach to informed medical consent

Informed consent as a legal concept exists in our common law in terms of Roman Dutch Law and the maxim "*volenti non fit injuria*" which translates into "to a willing person, injury is not done."²³ Based on the interpretation of common law through our courts, the principle of informed consent has been recognised and developed. The issue of informed consent in our law was dealt with in the precedent-setting case of *Stoffberg v Elliot*²⁴ in 1923 when the High Court determined that consent was necessary for medical surgery to ensure that an individual's right to bodily autonomy was not violated. This principle of autonomy was confirmed in 1957 in the case of *Esterhuizen v Administrator Transvaal* where the Court confirmed that consent was a requirement to the administration of any medical procedure.²⁵

Perhaps of more importance to the issue under discussion is the case of *Castell v de Greef*,²⁶ which is a 1994 case before a full bench of the Cape Town High Court in 1994. In this case, the plaintiff successfully sued the plastic surgeon (defendant) for a failed mastectomy operation. This was after the operation was recommended by the plastic surgeon as

20 As above.

21 GAHC Guidelines (2021) 17.

22 As above.

23 *Pandie vs Isaacs* [2013] ZAWCHC 123 at 33.

24 *Stoffberg v Elliot* 1923 CPD 128.

25 Naidoo "Esterhuizen v Administrator Transvaal: a case review" 2004 *The South African Radiographer* 7.

26 2 1994 (4) SA 408 (C).

a precautionary measure. Unfortunately, the operation was not a success. The plaintiff sued the plastic surgeon successfully for damages.²⁷

An issue that arose was the duty of disclosure by a surgeon when obtaining consent for the procedure. The decision of the Court in the *Castell* matter is important because the Court unpacked the issue of what informed consent entails with respect to health and medical treatment.²⁸ The court found that certain elements are critical for the process of obtaining consent for a person to be considered as having given consent. The Court explained the minimum level of consent currently required in South African law as follows:

the consenting party 'must have had knowledge and been aware of the nature and extent of the harm or risk; (b) the consenting party 'must have appreciated and understood the nature and extent of the harm or risk'; (c) the consenting party 'must have consented to the harm or assumed the risk'; (d) the consent 'must be comprehensive, that is extend to the entire transaction, inclusive of its consequences.'²⁹

Some authors posit that the use of the word "comprehensive" means that although the patient has consented to the operation, the conversation around the informed consent between the doctor and the patient does not stop upon such consent, but is a continuous discourse. This involves the duty of the doctor to inform the patient of what is expected post-operation once she/he/they has/have been discharged. According to Thomas, in a "patient-oriented approach" this is an important aspect that should be included in the *consent process*.³⁰ From this reasoning, consent is not merely a response to a question being asked. In law, it is viewed as requiring a specific process to be undertaken in an ongoing manner. The *Castell* matter explained that a doctor only has an obligation to disclose material risks associated with the proposed treatment or operation. The Court stated that to determine if a risk material depends on the specific circumstances of each case and whether "(a) a reasonable person in the patient's position, if warned of the risk, would be likely to attach a significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."³¹ This test was however not applied by the Court – the common law test, "a risk is material if the person who consented would not have done so had the risk been known to him", is what Court have applied in South Africa.³²

27 *Castell* para 411.

28 *Castell* para 425.

29 As above.

30 Thomas "Where to from *Castell v De Greef*? Lessons from recent developments in South Africa and abroad regarding consent to treatment and the standard of disclosure" 2007 *SALJ* 192.

31 *Castell* para 426.

32 Thomas 2007 *SALJ* 192.

The Court in *Castell* confirmed the patient-centric nature of how informed consent is understood. Accordingly, in South African law the patient must have access to all the relevant information related to their diagnoses and treatment, but that they also appreciate and understand the risks involved in the treatment as well as the very real harm they may suffer because of the treatment. The approach taken in the *Castell* matter is consistent with the framework of the Constitution of South Africa especially the entrenchment of rights to human dignity, and bodily integrity which emphasises that South African society is founded on the underlying values of individual autonomy and self-determination.³³

More recently and under our constitutional democracy, the High Court has confirmed the right to bodily autonomy and for an individual to make decisions about their bodies in *Christian Lawyers Association v the Minister of Health*,³⁴ which dealt with the adoption of the Choice of Termination of Pregnancy Act 92 of 1996. The Court in the *Christian Lawyers Association* matter emphasised that the recognition of the right of every individual to self-determination is an imperative entrenchment under the Constitution and particularly the following provisions of the Bill of Rights namely:

- section 12(2), “everyone” has the right to bodily and psychological integrity which includes the right “to make decisions concerning reproduction” and “the security and control over their body”.
- section 27(1)(a), “everyone” has the right to have access to “health care services”.
- section 10, “everyone” has “inherent dignity and the right to have their dignity respected and protected.”³⁵

Consent cannot be hurried. The patient must be given enough time to consider the information before making an informed decision. Our Courts have confirmed this approach in the case of *Isaacs v Pandie*³⁶ where the plaintiff, a 32-year-old woman, was sterilised following a pre-planned caesarean operation with her consent. The plaintiff argued that performing the sterilisation without her consent was a breach of contract and violated the provisions of the Sterilisation Act 44 of 1998 and certain guidelines as published by the Medical and Dental Professions Board of the Health Professions Council of South Africa (HPCSA).³⁷

The Court in its decision placed emphasis on time and consideration of the information before the patient for informed consent to be seen as having been given.³⁸ Furthermore, it is the physician’s obligation to ensure that they have conveyed all the relevant information to the

33 See *Christian Lawyers Association v the Minister of Health* para 26. See also Thomas 2007 SALJ 189.

34 2004 4 SA 31 (T).

35 *Christian Lawyers Association v the Minister of Health* para 27.

36 *Pandie v Isaacs* [2013] ZAWCHC 123.

37 *Pandie v Isaacs* para 4.

38 *Pandie v Isaacs* para 90.

patient, and that such information has been understood, and that the patient has been afforded sufficient time to process such information.³⁹

It appears that the appropriate approach is the one taken by the court in the *Christian Lawyers Association's* case where it was stated that there is no one-size-fits-all approach to the issue of consent.⁴⁰ It is simply put to be decided on a case-by-case basis given the physician's assessment of the patient's emotional and intellectual capacity and maturity to appreciate and understand the information that they have been provided with. The Court specifically stated that the Choice of Termination of Pregnancy Act makes informed consent and not age, the cornerstone of its regulation of access to termination of pregnancy.⁴¹ This is indeed not only limited to termination of pregnancy.

3 2 The National Health Act 61 of 2003

Informed consent as a concept is not defined in the National Health Act (NHA). The language in section 6 of the NHA speaks to the obligation of the health care facility to ensure that the patient has been informed of their health prognoses in a way the individual understands, which includes the diagnosis, treatment and procedures that may accompany their care.⁴² The section clearly provides that the patient must also be advised of the cost implications, risks associated with the recommended treatment or intervention and the consequences of their choice.⁴³ The individual must also be advised of their right to refuse intervention and the likely result of such refusal.⁴⁴ Section 6 must be read with sections 7 and 8 as these three sections encapsulate what informed consent – as a process – entails. Section 7 provides that:

7. Consent of user
 - (1) Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless–
 - (a) the user is unable to give informed consent and such consent is given by a person–

39 As above.

40 *Christian Lawyer's Association v Minister of Health* para 57.

41 *Christian Lawyer's Association v Minister of Health* para 19.

42 S 6 states: "(1) Every health care provider must inform a user of – (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal. (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy.

43 As above.

44 S 6(1)(d) of the National Health Act.

- (i) mandated by the user in writing to grant consent on his or her behalf; or
 - (ii) authorised to give such consent in terms of any law or court order;
 - (b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed;
 - (c) the provision of a health service without informed consent is authorised in terms of any law or a court order;
 - (d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or
 - (e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.
- (2) A health care provider must take all reasonable steps to obtain the user's informed consent.

In terms of section 7(3) informed consent means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6. Section 8 goes further and states that the process of consent is mandatory and participatory in nature.⁴⁵ According to this section, a user has the right to participate in any decision affecting his or her personal health and treatment and where consent of another person is required, then such person, if possible, must consult with the user before giving the required consent.⁴⁶ Even if the user lacks capacity but is capable of understanding, then such a user must be informed as provided in sections 6 and 7 of the Act.⁴⁷ Lastly, if the health care service was provided without the participation of the user, and such a decision affects his or her personal health and treatment, he or she must be informed as contemplated in section 6 unless it is contrary to their best interests.

So even though the legal framework does not use the exact phrase or term, the criteria and requirements set out in both sections 6 and 8 clearly incorporate the legality associated with informed consent as set out in the common law and developed by our Courts over time.⁴⁸ It is clear that from above, the National Health Act sets out extensive provisions that indicate the importance of informed consent for medical treatment. However, it has been said that it is equally important for medical practitioners to apply the set ethical rules relating to informed consent as being cast in stone and binding so as to promote the interests

45 S 8(1) of the National Health Act.

46 S 8(2)(a) of the National Health Act.

47 S 8(2)(b) of the National Health Act.

48 S 8(3) of the National Health Act.

of patients.⁴⁹ While the above approach is not child-specific, it is very important in informing the approach to obtaining informed consent from children.

4 The South African legal framework on informed consent to medical treatment for children and gender-affirming treatment

4 1 The Children's Act 38 of 2005

The Children's Act 38 of 2005 (hereinafter the Children's Act) is the primary law which governs the provision of a range of rights and services for children and families. The Children's Act aims to support families in ensuring their children's well-being, to prevent the abuse and neglect of children, and to ensure that children in need of care and protection are provided with appropriate care.⁵⁰ The Children's Act in essence deals with the rights of minor children in that it sets the legal age of majority at 18 years in section 17 of the Act.

Sections 129 (2)(a) and 129(2)(b) of the Children's Act, provide that a child can consent to his or her own medical treatment or to the medical treatment of their child. Provided that the child is aged 12 or older; and is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. Where the child is under 12 years of age, parental consent is necessary.

Sections 129(3)(a), 129(3)(b) and 129(3)(c) of the Children's Act empower a child to consent to the performance of surgical operation with the assistance of his/ her/their parents. The discussion herein focuses on the contents of section 129(2) on 'medical treatment' and does not delve into the position relating to surgical procedures. Section 129(2) of the Children's Act makes specific reference to the term "medical treatment", but does not define what this means. It appears that South African legislation has not attempted to define the term 'medical treatment' as the Children's Act, National Health Act; Mental Health Care Act 2002; the Prevention and Treatment of Substance Abuse Act 2008,⁵¹ or any other national health legislation and policy entail no such definition. Nonetheless, the GAHC Guidelines state that the term "medical treatment" is widely understood to be a manifestation of the right to health as provided for in section 27 of the Constitution.⁵² Furthermore, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions

49 Veriava "Ought the Notion of 'Informed Consent' to be cast in Stone? *VRM v The Health Professions Council of South Africa*" 2004 *South African Journal on Human Rights* 320.

50 Preamble of the Children's Act.

51 Prevention and Treatment of Substance Abuse Act 70 of 2008.

52 GAHC Guidelines (2021) 21.

necessary for the realisation of the highest attainable standard of physical and mental health.⁵³

Central to recognising children's rights to consent to medical treatment is the right of children to participate in all matters that affect them, which is codified in our Children's Act and the UN Convention of the Rights of the Child.⁵⁴ This is a core principle which asserts that children have the right to express their views and to participate in any matter concerning that child based on the child's age, maturity and stage of development.⁵⁵ Children aged 12 and above are permitted to seek out medical assistance, sexual and reproductive health interventions and HIV Tests among others.⁵⁶

The Constitution also guarantees children the rights to equality,⁵⁷ dignity,⁵⁸ freedom and security of the person,⁵⁹ and health, including the right to make decisions about their own reproduction among others.⁶⁰ In addition, the Constitutional Court has recognised the rights of children to privacy and human dignity.⁶¹ The guarantee of everyone's right to bodily and psychological integrity, also called the right to physical integrity, which includes the right to make decisions concerning reproduction; the right to security in and control over one's body; and the right not to be subjected to medical or scientific experiments without informed consent is a paramount right.⁶²

Section 129 of the Children's Act must be read with sections 6, 7 and 8 of the National Health Act in so far as it enhances what the process of obtaining informed consent entails. In particular, section 129(2)(b) requires that the child should have sufficient maturity and mental capacity to understand the benefits and risks, social and other implications of the treatment, which in my view cannot be obtained without a process as set out in section 6 of the National Health Act. The additional caveat that I would argue is needed here, is that the process set out in section 129(2)(b) has to take place in a child-appropriate manner and information must be provided in a manner that is accessible

53 See Office of the High Commissioner for Human Rights, CESCR General Comment No 14: The right to the Highest Attainable Standard of Health (art 14) para 9.

54 S 10 of the Children's Act and art 12 of the UN Convention on the Rights of the Child.

55 See Buchner-Eveleigh "Is it a competent child's prerogative to refuse medical treatment?" 2019 *De Jure Law Journal* 246 where she discusses children's right to autonomy or self-determination as being the quintessence of the right to bodily integrity.

56 Ss 130–134 of the Children's Act.

57 S 9 of the Constitution.

58 S 10 of the Constitution.

59 S 12 of the Constitution.

60 S 17 of the Constitution.

61 See n 5 above.

62 See *Teddy Bear Clinic* paras 52–58 on dignity; paras 59–64 on privacy; and paras 65–79 on how the rights to dignity and privacy must be read in a manner that promotes the best interests of the child.

to the specific child. In addition to the provisions of section 129, section 13 of the Act is instructive in so far as providing for children's rights to access information on health care:

13. (1) Every child has the right to –
 - (a) have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction;
 - (b) have access to information regarding his or her health status;
 - (c) have access to information regarding the causes and treatment of his or her health status; and
 - (d) confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child.
- (2) Information provided to children in terms of this subsection must be relevant and health status; and must be in a format accessible to children, giving due consideration to the needs of disabled children.

Therefore, those providing medical treatment to children have a defined obligation to provide children with extensive information which would then inform the process towards the child giving consent to any medical treatment.

4 2 Do the Gender Affirming Healthcare Guidelines⁶³ (GAHC Guidelines) align with the Children's Act and National Health Act in relation to informed consent for gender reaffirming treatment for children

The GAHC Guidelines were adopted by Southern African HIV Clinicians Society and the purpose of these guidelines is “to provide evidence-informed best practice recommendations to enable health care providers to offer quality, affirming services to transgender and gender diverse clients as well as to support these clients when accessing healthcare services”.⁶⁴ One of the central issues in the GAHC Guidelines is how to approach the cases of children who present for gender-affirming treatment such as hormone treatment- puberty blockers. The GAHC Guidelines provide that in general there should be differentiation between children under the age of 12 years and those over the age of 12 years in so far as accessing gender-affirming treatment.⁶⁵ In relation to children under the age of 12, the GAHC Guidelines provide that the healthcare providers must engage parents/legal guardians for psychosocial care for TGD children and address the limitations of confidentiality with the child while assuring the child that they support them.⁶⁶ In so far as children older than 12 years old, the Guidelines express that the approach to informed consent for psychosocial care is

63 GAHC Guidelines (2021).

64 GAHC Guidelines (2021) 9.

65 GAHC Guidelines (2021) 21.

66 As above.

more complex as it may include mental health evaluation, support and counselling as well as medical intervention in the form of puberty suppression and possible hormone therapy.⁶⁷

In so far as informed consent for puberty suppression or hormone therapy for adolescents the GAHC Guidelines indicate that the Children's Act considers children above 12 years of age competent and of sufficient capacity to give informed consent to the treatment.⁶⁸ Importantly, the Guidelines indicate that informed consent is a continuous process rather than a single event and clinicians must observe that adolescents have evolving capacity over time as they mature.⁶⁹ The GAHC Guidelines go further to provide how informed consent from an adolescent should be obtained and clearly indicate that

(i) it should be in an collaborative, supportive context of a multi-disciplinary team with noted expertise in assessing and intervening in adolescent physical, psychological and social development; (ii) with an appreciation of the influence of family dynamics, as far as possible with the support and involvement of parents/legal guardians as better family support for TGD youth is associated with better mental health outcomes -however the lack of support does not preclude access to treatment; and (iii) with emphasis that the adolescent needs to understand all risks and benefits of the treatments and have considered the reproductive health implications and options.⁷⁰

The GAHC Guidelines go further to detail the approach to informed consent for surgery for TGD adolescents, but that is beyond the scope of this article.⁷¹

The GAHC Guidelines provide that psychosocial care and treatment to children must be approached in a manner that considers the child as an individual, as a member of a family, as a member of a school; as a member of community and as member of broader society.⁷² The GAHC Guidelines appear to follow the provisions of the Children's Act in so far as the approach to the age of consent to medical treatment is concerned, while providing crucial guidance as to how informed consent must be obtained from children of 12 and above. It is also encouraging that these Guidelines emphasise that providing informed consent is a process and not an event. This holistic approach is essential not only to protect children's short and long-term best interests but also to minimise the risk of medical practitioners being opened up to the risk of litigation, as will be seen from the cases in the United Kingdom where the courts had to

67 GAHC Guidelines (2021) 22. The Guidelines indicate how the process for consent and treatment is a multi-disciplinary one and also requires consultation with parents/legal guardians and where the parents/legal guardians are not acting in the best interest of the child there may be a need for referral to other professionals.

68 GAHC Guidelines (2021) 23.

69 As above.

70 As above.

71 As above.

72 GAHC Guidelines (2021) 38-46.

deal with whether children can provide informed consent to gender-affirming treatment and surgery.

5 Lessons from the United Kingdom: The case for a careful approach to counselling and gender reaffirming treatment for children

The question as to whether children can or should consent to gender-reaffirming treatment was recently dealt with in three cases in the United Kingdom and these cases present learnings that can benefit South African medical practitioners and courts should they be faced with this question. This trio of cases illustrate the complex nature of consent for gender-affirming treatment for children.

5.1 *Bell v The Tavistock and Portman NHS Foundation Trust*⁷³

The case was a judicial review of the lawfulness of the practice of the Tavistock and Portman NHS Trust, through its Gender Identity Development Service (GIDS) of prescribing puberty-suppressing drugs to children who experience gender dysphoria.⁷⁴ The puberty-blocking drugs were prescribed to children as young as 10 to halt the process of puberty, that is the biological processes that would otherwise occur and would lead to the development of the primary and secondary sexual characteristics.⁷⁵

The applicants were Quincy Bell, who was born a female and, at about the age of 15, was prescribed puberty-blocking drugs to halt the process of developing female sexual characteristics.⁷⁶ She eventually transitioned to a male having taken cross-sex hormones to promote male characteristics and then undergoing surgery.⁷⁷ A was the second applicant and the mother of a 15-year-old girl. A was concerned that her daughter may be referred to the Gender Identity Development Service and may be prescribed puberty blockers.⁷⁸ Both Bell and A argued that the practice of prescribing puberty-blocking drugs to children under 18 was unlawful as they lacked the competence to give valid consent to the treatment.⁷⁹ The Tavistock and Portman NHS Foundation Trust, in their defence, provided details of the procedures followed by medical professionals, including the length of the required pre-procedural assessments and the extensive analysis of the children undertaken by

73 [2020] EWGC 3274.

74 *Bell v Tavistock* paras 2–3.

75 *Bell v Tavistock* para 3.

76 *Bell v Tavistock* paras 7, and 78–84.

77 *Bell v Tavistock* para 84.

78 *Bell v Tavistock* para 89.

79 As above.

professionals at the clinic.⁸⁰ They placed emphasis on the amount of information provided to the children regarding the procedure and that they only refer a child aged under 16 for puberty-blocking treatment if the child is considered to be Gillick competent, i.e. if they have “sufficient understanding and intelligence to understand the nature and implications of the proposed treatment”.⁸¹

The court had to decide on what are the legal requirements for obtaining consent for the carrying out of medical treatment.⁸² Importantly, the court was not concerned with deciding whether there were benefits or disbenefits in treating children with gender dysphoria with puberty blocking drugs⁸³. Therefore, the legal issue in the case concerned identifying the circumstances in which a child was competent as a matter of law to give valid consent to treatment.⁸⁴

The court held that in order for a child to be competent to give valid consent the child would have to understand, retain and weigh the following information:⁸⁵

- i the immediate consequences of the treatment in physical and psychological terms;
- ii the fact that the vast majority of patients taking puberty blocking drugs proceed to taking cross-sex hormones and are, therefore, a pathway to much greater medical interventions;
- iii the relationship between taking cross-sex hormones and subsequent surgery, with the implications of such surgery;
- iv the fact that cross-sex hormones may well lead to a loss of fertility;
- v the impact of cross-sex hormones on sexual function;
- vi the impact that taking this step on this treatment pathway may have on future and life-long relationships;
- vii the unknown physical consequences of taking puberty blocking drugs; and
- viii the fact that the evidence base for this treatment is as yet highly uncertain.

According to the court, it was highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers.⁸⁶ Furthermore, that it was also doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blocking drugs.⁸⁷ In so far as young persons aged 16 and over are concerned, the court indicated that the legal position is that there is a statutory presumption that they have the ability to consent to medical treatment, however, given the long-term consequences of the clinical interventions at issue in this case, as well as

80 *Bell v Tavistock* paras 36–46.

81 As above.

82 *Bell v Tavistock* para 9.

83 As above.

84 *Bell v Tavistock* para 133.

85 *Bell v Tavistock* paras 133–8.

86 *Bell v Tavistock* para 145.

87 *Bell v Tavistock* paras 145 and 151.

the innovative and experimental nature of the treatment, clinicians may well regard these as cases where the authorisation of the court should be sought before starting treatment with puberty-blocking drugs.⁸⁸ The court granted the declarations sought by the applicants,⁸⁹ however, the matter was appealed by Tavistock and the appeal decision is dealt with hereunder.

Subsequent to the judgment, concerns arose in relation to whether children could consent to medical treatment in general and how this judgment also affected other aspects of decision-making. The judgment, for instance, could be considered to negate the established Gillick Competence⁹⁰ and the evolving capacity of children. Article 5 of the UNCRC places an obligation on State Parties to respect the roles, responsibilities and rights that parents including, where applicable extended family or community and/or legal guardians exercise and as well as guidance towards their children, that is in accordance or in a manner that is consistent with their evolving capacity. Furthermore, General Comment No 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art 24) provides for the approach to recognising children's evolving capacities and states, amongst others, that "it is essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality".⁹¹ The General Comment further provides that:

children should, in accordance with their evolving capacities, have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests and that States should clarify the legislative procedures for the designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child's behalf or assist the child in consenting, depending on the child's age and maturity. States are enjoined to review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services.⁹²

Some concerns were immediate in that there were children already undergoing gender-affirming treatment and now parents and clinicians questioned whether they could continue such treatment pending the appeal. This led to the *AB v Tavistock* case discussed below.

88 *Bell v Tavistock* paras 146–7 and 152.

89 *Bell v Tavistock* para 152.

90 The Gillick Competence test is an established principle in the case of *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112 where the House of Lords held by a majority that a doctor could lawfully give contraceptive advice and treatment to a girl aged under 16 if she had sufficient maturity and intelligence to understand that nature and implications of the proposed treatment and provided that certain conditions were satisfied.

91 General Comment 15 para 21.

92 General Comment 15 para 31.

5.2 *AB v CD*⁹³

While the *Bell v Tavistock* appeal was pending, a mother, AB, of a child, XY, who was 15 at time of judgement, sought a declaration that she and the father of XY, CD, were able to consent to the administration of “puberty blockers”.⁹⁴ This was because following *Bell v Tavistock*, the NHS amended its guidelines so that patients undergoing hormone therapy needed a ‘best interests’ application to the court before treatment could continue.⁹⁵ Furthermore, in *Bell*, it was held that a child would need to have Gillick competence to consent to the administration of puberty blockers.⁹⁶ The first key question was whether the parents still have the legal ability to consent to treatment for their children undergoing hormone therapy.⁹⁷ The court held that it was irrelevant whether XY was Gillick competent or not. If they were, they could consent on their own behalf. If they were not, then their parents would be able to do so. Where the child does not make the decision themselves, then the parents have the right to provide consent for their child if they deem it to be in the child’s best interests.⁹⁸ Therefore held that the parents did have the right to consent to that treatment.⁹⁹

The second question before the court was whether the administration of puberty blockers fell under a special category of medical treatment which requires the consent of the Court on application before they can be prescribed.¹⁰⁰ Furthermore, even if the answer to the above is “no”, it is a matter of good practice that an application should be made to the court.¹⁰¹

The court looked at other cases and treatments that could fall under the “special category” and determined that these were largely fact-specific and in any case very limited and puberty blockers did not fall into this definition.¹⁰² Lieven J continued that, while *Bell v Tavistock* had cast doubt on the medical basis of puberty blockers, AB and CD would have weighed up the considerations prior to allowing XY to begin treatment.¹⁰³ XY was not found to have overly pressurised their parents to consent to treatment, although it was admitted this may not be the case in all other situations.¹⁰⁴ Where the parents are under pressure, or the child’s treatment team are conflicted as to how to proceed, then the matter should be referred to the court.¹⁰⁵

93 [2021] EWHC 741 (Fam).

94 *AB v CD* paras 11–25.

95 *AB v CD* paras 26–7.

96 *AB v CD* para 34.

97 As above.

98 *AB v CD* paras 67–70.

99 As above.

100 *AB v CD* para 34.

101 As above.

102 *AB v CD* paras 67–70.

103 *AB v CD* para 71.

104 *AB v CD* paras 120, 121 and 126.

105 *AB v CD* para 128.

5.3 *Bell v Tavistock 2*¹⁰⁶

The Court of Appeal had to decide whether the court in *Bell v Tavistock* was correct in declaring that it was highly unlikely that children 13 year or under would be Gillick competent to give consent to be treated with puberty blockers and that it was very doubtful that those aged 14 and 15 could understand the long-term risks and consequences of treatment in such a way to have sufficient understanding give consent.¹⁰⁷ Tavistock argued that court a quo had misapplied the Gillick competence test; that the court's conclusions were inconsistent with the Family Law Reform Act of 1969; that the court was incorrect that puberty blockers for gender dysphoria were experimental with life long and life changing effects; that the court approached the evidence adduced by the parties incorrectly and that the approach of the court discriminates against children with gender dysphoria and cannot be justified and therefore violates article 14 of the European Convention on Human Rights.¹⁰⁸

We focus, for the purpose of our discussion, on the Appeal Court's approach to the issue of the ability of children to consent to gender-affirming treatment. In this regard, the Appeal Court found that the court a quo should not have granted the declaration.¹⁰⁹ On the issue of whether the court a quo should have given guidance as to how children with gender dysphoria's consent should be confirmed by a court, the Court of Appeal stated that although the guidance stemmed from an understandable concern, it was not for the court to generalise about the capability of persons of different ages to understand what is necessary for them to consent to the administration of puberty blockers.¹¹⁰ That, moreover, it would be unhelpful for the court to make provision for a process of obtaining court-sanctioned approval as it would effectively result in a denial of treatment for those unable to afford such processes and would, in any event, lead to unnecessary delays.¹¹¹ With reference to the Gillick competence, the Appeal Court stated that it is for the clinicians rather than the court to decide on competence and particularly that "save where statute otherwise provides, a minor's capacity to make his or her own decision depends upon the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit."¹¹²

106 [2021] EWCA Civ 1363.

107 *Bell v Tavistock 2* paras 9–11.

108 *Bell v Tavistock 2* para 12. Art 14 of the European Convention on Human Rights provides that "the enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status".

109 *Bell v Tavistock 2* para 83.

110 *Bell v Tavistock 2* para 85.

111 *Bell v Tavistock 2* para 86.

112 *Bell v Tavistock 2* paras 87–8.

The Appeal Court found that it was inappropriate for the court a quo to have given guidance concerning when a court application would be appropriate and to reach general age-related conclusions about the likelihood or probability of different cohorts of children being capable of giving consent.¹¹³ However, the Appeal Court recognised that there may be instances where applications to the court may be appropriate.¹¹⁴

6 Conclusion

There appears to be parallels between the South African and the United Kingdom to how gender affirming treatment for children should be approached. First, both countries have established law for consent of children to medical treatment with or without support. These provisions have in turn informed the approach to the consent of children to gender affirming treatment. While these laws pertaining to the age and maturity to consent are central, the judgments from the United Kingdom illustrate how the procedures that lead to informed consent for gender affirming treatment are crucial in ensuring that the children and their families fully understand the nature and consequences of the treatment sought.

Secondly, there is also need to be cautious in so far as how the aforementioned consent(s) are obtained are obtained in a process that considers the interest of children, while rejecting a generalised paternalistic approach that would not only do harm to the question as to whether children can consent to gender-affirming treatment, but to the recognition of children's evolving capacities in general.

In the words of the court in *Bell v Tavistock 2*

We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in Gillick, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As Gillick itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested.¹¹⁵

The aforementioned approach would, in South Africa, mean that a position where children over the age of twelve are excluded from accessing gender-affirming treatment is contrary to section 129(2) of the Children's Act. Furthermore, such an approach would be tantamount to a revocation of the right of adolescents to access health services based

113 *Bell v Tavistock 2* para 88.

114 As above.

115 *Bell v Tavistock 2* para 92.

on age, sex and gender identity. The Children's Act makes provision for the developing capacity of a child and the individual child's maturity in sections 129(2) and 13 support this approach by requiring that children be provided information in relation to their health. The GAHC Guidelines are a step in the right direction in providing comprehensive guidance to those dealing with children seeking gender-affirming treatment to enable them to make informed decisions about their treatment. Lastly, the Constitutional Court has already provided guidance in the *Teddy Bear Clinic* case¹¹⁶ as to how children's right to dignity, privacy and their best interests should be read together to enable a recognition of their evolving capacities while providing the needed guidance to protect the short and long-term best interests.

116 See n 5 above.