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THE CAPABLE MINOR'S HEALTHCARE: WHO DECIDES?

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Who decides the medical treatment of a capable young person defined by statute to be a child—the young person's parents? the state or courts exercising parens patriae authority? or the young person? This article examines the intersection of medical practice and studies on developmental capacity, common law, parens patriae jurisdiction, provincial and territorial legislation, and rights and freedoms protected by the Canadian Charter of Rights and Freedoms. Guidance is found in an analysis of comparative law from the United Kingdom and the United States of America. Common law and Charter guarantees, together with the realities of a young person's cognitive and psychological development, and medical practice, submits the author, confirm that medical treatment decisions should be made by the capable young person.

Qui prend les décisions relatives au traitement médical d'une jeune personne capable qui est un enfant au sens de la loi—les parents de cette personne, l'État ou les tribunaux dans l'exercice de leur pouvoir parens patriae ou la jeune personne elle-même? Le présent article porte sur le point de rencontre entre l'exercice de la médecine et les études sur la capacité du développement, la common law, la compétence parens patriae, les lois des provinces et des territoires et les droits et libertés garantis par la Charte canadienne des droits et libertés. Des points de repère se trouvent dans l'analyse du droit comparé du Royaume-Uni et des États-Unis. Selon l'auteur, la common law et les droits garantis par la Charte, ainsi que les réalités liées au développement cognitif et psychologique

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d'une jeune personne et la pratique de la médecine confirment que les décisions relatives à des traitements médicaux devraient être prises par la jeune personne capable.

1. Introduction

The term “child” is synonymous with innocence and vulnerability. A child needs nourishment and nurture; care and control; protection and direction; teaching and treatment. Mirroring common law premises, some dating from the birth of legal memory (September 3, 1189),¹ most children in Canada reside with one or both of their parents, who are typically best suited to afford and fulfill these essential needs, including decisions about health care.²

Where a child’s parents or other personal guardians are unable or unwilling to satisfy these needs, the state must intervene. Intervention relies on exercise of the Crown’s *parens patriae*³ jurisdiction for care of children, as well as of mental incompetents. The genesis of this jurisdiction lies in antiquity.⁴ Its current vehicles are primarily legislatures and courts. Its exercise is manifested in legislation largely dedicated to child welfare, in judicial orders envisaged by legislation and in common law principles.⁵ One example of its effect is to task the state to serve in the stead of a child’s personal guardian(s), temporarily or permanently, depending on the nature, severity and duration of child neglect or mistreatment.⁶ Its pliant scope includes legislative and judicial *parens patriae* authorization of state intervention, in the place of personal guardians, to consent to and monitor a child’s medical treatment.

¹ Sir William Holdsworth, *Some Makers of English Law: The Tagore Lectures, 1937-38* (Buffalo: William S. Hein-Company, 1983) at 8.

² *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 at 372 [B.(R.)]. The author of this article was counsel for B.(R.).

³ Literally “parent of the land.”

⁴ *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388 at 407-18 [Eve].

⁵ “Best interests” decision-making by the courts about child custody and access is another example.

⁶ See generally: *D. (B.) v. Children’s Aid Society of Halton (Region)* (2007), 39 R.F.L. (6th) 245 (S.C.C.) at paras. 1-2; Nicholas Bala, “An Introduction to Child Protection Problems” in Nicholas Bala, Michael Kim Zapf, R. James Williams, Robin Vogl and Joseph P. Hornick, eds., *Canadian Child Welfare Law: Children, Families and the State*, 2nd ed. (Toronto: Thompson Educational Publishing Inc., 2004) c. 1 at 1-2. Under most provincial and territorial legislation the state, where vested with permanent responsibilities for a child, may place the child for adoption.

But when is parental, legislative or judicial authority to intervene in medical care of a child eclipsed by the rights of a young person who, though a “child” according to definitions based on age, has become capable of making her or his health care treatment decisions? When may that capable young person consent to or dissent from personal health care treatment recommended by that young person’s treating physician? Choose alternative medical treatment preferred by that person, whether consent is given or dissent expressed in sickness (including life-threatening circumstances) or in health? Or make legally-recognized decisions about contraception, abortion, disease prevention and control, or tissue donation, based on wishes expressed contemporaneously or in an advance medical directive?

In other words, when is a young person entitled, at common law or under statute, to make autonomous binding decisions about his or her own health care rather than having these decisions made by a personal guardian, or by a legislature or court exercising *parens patriae* jurisdiction? The author concludes that this point arrives when the young person is capable of making her or his medical treatment decisions.

A further question is whether a legislature or a superior court asserting *parens patriae* jurisdiction may impose restrictions on the right of a capable young person to make autonomous binding decisions about health care. The author concludes that neither the legislature nor the court can impose such restrictions.

A global common law definition of a “child,” termed the “Rule of Sevens,” comprises multiples of seven, each signifying a stage of a child’s capacity and concomitant privileges and disabilities. Basically, at common law, a child lacks capacity until seven years old; is subject to a rebuttable presumption of incapacity from seven to fourteen years old (fourteen being the commencement of the age of discretion); and a rebuttable presumption of capacity from fourteen to twenty-one years old (twenty-one years being the common law age of majority).⁷

In obtaining authority for a child’s treatment, reports Lorne E. Rozovsky in *The Canadian Law of Consent to Treatment*, “Many Canadian hospitals and health professionals are reluctant to accept the consent of patients under the [common law] age of majority [of twenty-one years].”⁸

⁷ Sir William Blackstone and George Chase, *The American Students’ Blackstone Commentaries on The Laws of England*, 3d ed. (Albany, N.Y.: Banks & Bros., 1903) at 175-83.

⁸ Lorne E. Rozovsky, *The Canadian Law of Consent to Treatment*, 3d ed. (Markham, ON: LexisNexis Butterworths, 2003) at 80-81.

Instead, perhaps prompted at least in part by their professional liability insurers or counsel, some of them seek consent from a child's personal guardian(s) or, absent guardians, other next of kin or the state. In so doing, they misapprehend medical treatment consent law.

First, consent to a child's medical treatment is not, as a general rule, required at common law "if [i] the child's life or health is immediately threatened, [ii] the parents cannot be contacted and [iii] the child is not capable of consenting [due to intellectual or physical reasons]."⁹ In these circumstances, a doctor may rely on common law emergency treatment authority. Second, the common law age of majority, twenty-one years, has in all provinces and territories been statutorily lowered to eighteen or nineteen years, although it "cannot be taken as the [statutory] age of consent, unless the [involved] legislation specifically states that the age is set for that purpose."¹⁰ And, third, attainment of a particular numerical age in and of itself, whether prescribed statutorily or at common law, affords no warranty—legally or practically—of capacity to furnish effective consent to medical treatment.

Rather, "the most satisfactory solution" of this issue, contends Lord Nathan in *Medical Negligence*,¹¹ is resort to what common law terms the "mature minor" rule, which contemplates that a person under the common law age of majority who is capable of appreciating the nature and consequences of a particular operation or other treatment, whether recommended by the treating physician or chosen by the capable young person, can give an effective consent without anyone else's approval being required. Where the young person lacks that capacity, however, any apparent consent by her or him will be a nullity, in which event consent is required from the young person's personal guardian(s) or from the state.

In Canada, provincial and territorial legislative enactments and judicial pronouncements on the rights of capable young people to decide their medical treatment have been inconsistent, notwithstanding the advent of the *Canadian Charter of Rights and Freedoms*.

First examined, specifically, are provincial and territorial legislative inconsistencies; illustrating the importance of resolving the question: "Who decides the medical care of capable young persons?"

⁹ *Ibid.* at 88.

¹⁰ *Ibid.* at 81.

¹¹ The Right Hon. Lord Nathan, P.C., *Medical Negligence* (London: Butterworth & Co. Ltd., 1957) at 176; see also Sarah Elliston, *The Best Interests Of The Child In Healthcare* (London: Routledge-Cavendish, 2007) at 95, 143.

2. *Inconsistent Recognition of Treatment Decision Rights of Capable Young Persons*

a) *Overview*

Framing the legal issues concerning consent to health care treatment by a capable young person first requires a brief analysis of the content and judicial interpretation of provincial legislation, and a survey of applicable common law, as well as consideration of the interface of legislation and common law germane to health care.

All provinces, with the exception of Nova Scotia, the Northwest Territories, and Nunavut, have legislation addressing, globally, consent to medical treatment. Additionally, all provinces and territories have child welfare legislation which defines “child” as a person under a particular age, specified as being either sixteen,¹² eighteen¹³ or nineteen.¹⁴ Child welfare legislation, however, is a legislative expression of the state’s *parens patriae* jurisdiction and as such does not—or, at least should not—apply to persons of any age who are capable of deciding on medical care for themselves.

In *Starson v. Swayze*, the Supreme Court of Canada concluded, in the context involving an adult patient, that at common law a capable person “has the right to refuse treatment, even if that treatment is, from a medical perspective, in his or her best interest.”¹⁵

Do the treatment instructions of a capable person—a “mature minor” at common law—who is under the common law age of majority govern as they would in the case of an adult? A survey of provincial and territorial legislation reveals a patchwork of divergent responses to the question. Some provinces and territories eschew an arbitrary age for medical consent, others set a rebuttable age of capacity, still others

¹² *Children and Family Services Act*, S.N.S. 1990, c. 5, s. 3(1)(e); *Child and Family Services Act*, S.N.W.T. 1997, c. 13, s. 1; *Child, Youth and Family Services Act*, S.N.L. 1998, c. C-12.1, s. 2(1)(d); *Child Protection Act*, R.S.P.E.I. 1988, c. C-5.1, s. 1; *Child and Family Services Act*, R.S.O. 1990, c. C.11, s. 37(1); *The Child and Family Services Act*, S.M. 1985-86, c. 8, C.C.S.M. c. C80, s. 25(9); *The Child and Family Services Act*, S.S. 1989-90, c. C-7.2, s 2(1).

¹³ *Children's Act*, R.S.Y. 2002, c. 31, s. 107; *Child, Youth and Family Enhancement Act*, R.S.A. 2000, c. C-12, s. 1(1); *Youth Protection Act*, R.S.Q., c. P-34.1, s. 1(c); *Family Services Act*, S.N.B. 1980, c. F-2.2, s. 1.

¹⁴ *Child, Family and Community Service Act*, R.S.B.C. 1996, c. 46, s. 1(1).

¹⁵ *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722 at para. 19 [*Starson*] (see also paras. 7, 75-76, 112); see also *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 at 135 [*Ciarlariello*].

prescribe an arbitrarily set age for consent to medical treatment. Judicial treatment of a capable minor's common law right to decide her or his own health care is equally divergent.

b) Analysis of Legislation and Case Law Interpretation

1) Jurisdictions that Presume All Persons are Capable of Deciding Their Medical Care

Ontario, in which reside more than one-third of Canada's adolescents, recognizes that capable persons of any age may decide their own medical treatment.¹⁶ Some consider Ontario's *Health Care Consent Act, 1996*¹⁷ "the most advanced legislation in the world in protecting the rights of both the capable or competent patient as well as the incapable or incompetent patient in the health care field."¹⁸ Prince Edward Island and Yukon have followed suit and enacted health care consent legislation explicitly recognizing that capable persons of any age have the exclusive right to decide their own medical care.¹⁹

The *Health Care Consent Act, 1996* of Ontario prohibits administration of treatment to a presently capable person of any age without that person's contemporaneous consent.²⁰ Consent by another—a parent, children's aid society, or a court—may be substituted only if a minor is presently incapable (due to the nature of the minor's illness). Even then, the substitute decision-maker must provide consent in accordance with the young person's known and applicable treatment instructions if expressed orally or through an advance health care directive made while the minor was capable.²¹ The Act codifies the common law with the exception that a person under the age of sixteen is precluded from making a valid advance health care directive. The rationale for that sole digression from the common law is the apparent difficulty of determining after the fact whether a presently incapable person under sixteen was capable when the directive was earlier executed.²²

¹⁶ Statistics Canada, *Age (123) and Sex (3) for the Population of Canada, Provinces, Territories, Census Divisions and Census Subdivisions*, 2006 Census (Ottawa: Statistics Canada, July 17, 2007).

¹⁷ *Health Care Consent Act, 1996*, S.O. 1996, c. 2, ss. 4(1), 10(1).

¹⁸ Brian F. Hoffman, *The Law of Consent to Treatment in Ontario*, 2d ed. (Toronto: Butterworths, 1997) at 1.

¹⁹ *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, c. 10, ss. 3(1), 4; *Care Consent Act*, S.Y. 2003, c. 21, ss. 3, 6(2),(3).

²⁰ *Supra* note 17 at s. 10(1).

²¹ *Ibid.* at s. 21(1).

²² Ontario, Legislative Assembly, Standing Committee on Administration of

Even before enactment of its *Health Care Consent Act, 1996*, however, Ontario recognized that the state could not authorize treatment for a presently capable young person under sixteen. Ontario's *Child and Family Services Act* gives a children's aid society "no greater right to consent than that recognized for parents at common law."²³ This is because the common law has long recognized parental authority to decide medical treatment terminates when the young person achieves consenting capacity.

Some provincial Canadian courts have questioned whether child protection legislation supersedes the common law "mature minor" rule or health care consent legislation. In Ontario, that question has been answered in the negative. In *H.(T.) v. Children's Aid Society of Metropolitan Toronto*, a case predating the *Health Care Consent Act, 1996*, Wilson J. accepted the position of the parties and the Attorney General of Ontario that a capable young person has the exclusive legal right to decide his or her own medical treatment.²⁴ In *Lewis v. Children's Aid Society of Metropolitan Toronto*, decided since enactment of the treatment consent legislation, MacDonald J. held that Ontario's *Health Care Consent Act, 1996*, and *Child and Family Services Act* "operate together harmoniously,"²⁵ authorizing a children's aid society to consent to medical treatment for an "incapable" person in care of the children's aid society.²⁶ Both rulings confirm that *state* authority to consent to treatment for a young person is no greater than the authority of the young person's personal guardian(s); an authority that, at common law, terminates when the young person achieves consenting capacity.

2) Jurisdictions with a Rebuttable Presumption of Incapacity Under the Age of Sixteen

Because Manitoba and Newfoundland and Labrador, unlike Ontario, have not enacted legislation concerning contemporaneous health care

Justice, "Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1995" in *Official Report of Debates (Hansard)*, No. J-17 (27 February 1996) at 642, 644.

²³ Gilbert Sharpe, "Consent and Minors" (1993) 13 *Health Law in Canada* 197 at 204-06.

²⁴ *H.(T.) v. Children's Aid Society of Metropolitan Toronto* (1996), 138 D.L.R. (4th) 144 at 156 (Ont. Gen. Div.).

²⁵ *Lewis v. Children's Aid Society of Metropolitan Toronto* (8 December 2000), Toronto 00-CV-202109 (Ont. S.C.J.), endorsement of Justice MacDonald [*Lewis*].

²⁶ *Ibid* [emphasis added]. In *British Columbia (Director of Child, Family and Community Service) v. B.(S.J.) (Litigation Guardian of)* (2006), 270 D.L.R. (4th) 536 (Ont. C.A.) [*B.(S.J.) Ont.*], Rosenberg J.A. noted it was unnecessary in that case to

instructions, the common law governs entitling capable minors to give such instructions. Both provinces have, however, enacted advance health care directives legislation recognizing that capable persons of any age may give binding future health care instructions. That legislation adopts a presumption that persons under sixteen are incapable of deciding their medical treatment, a presumption which may be rebutted, however, by adduction of evidence of the minor's capability.²⁷

(Although it is impractical to expect an advance directive to predict and memorialize treatments a person *does* want for every conceivable illness he or she may in future encounter, the directive can at least dependably articulate treatments he or she *does not* want, such as blood transfusions or particular surgical procedures or medications, irrespective of the myriad illnesses which could be experienced.)

The *Mental Health Act* of Manitoba goes even further than its *Health Care Directives Act*, by recognizing that in circumstances when the *Mental Health Act* is invoked the medical treatment instructions of a capable person under sixteen, whether contemporaneously expressed orally or through an advance health care directive, are binding on health care providers, the court, the Mental Health Review Board, the Public Trustee, and court-appointed committees.²⁸

As stated by the Manitoba Law Reform Commission, Manitoba's *Health Care Directives Act*, *Mental Health Act*, and *Child and Family Services Act*²⁹ reflect the legislature's policy "that a finding of capacity places the minor in the same position in respect of health care as an adult."³⁰ Or, as stated by the Minister of Health when the *Mental Health Act* was enacted, the three pieces of legislation reflect the legislature's policy rejecting a "fixed age"³¹ for medical consent in favor of an

pronounce on the precise relationship between Ontario's *Health Care Consent Act*, 1996, and Ontario's child welfare legislation. He stated, however, at 551: "I do not say that such an application [to interfere with a mature minor's choice of treatment] would succeed or was even feasible or that an Ontario court would exercise jurisdiction in such a case."

²⁷ *The Health Care Directives Act*, S.M. 1992, c. 33, C.C.S.M. c. H27, s. 4(2)(b); *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1, s. 7(c).

²⁸ *The Mental Health Act*, S.M. 1998, c. 36, C.C.S.M. c. M110, ss. 2, 26, 29, 56(1), 59(3), 69(3), 91.

²⁹ *The Child and Family Services Act*, S.M. 1985-86, c. 8, C.C.S.M. c. C80.

³⁰ Manitoba, Law Reform Commission, *Minors' Consent to Health Care*, Report No. 91 (Manitoba: Queen's Printer, 1995) at 9, 32, 33, 38 [MLRC, *Minors' Consent*].

³¹ Manitoba, Law Reform Commission, *Self-Determination in Health Care (Living Wills and Health Care Proxies)*, Report No. 74 (Manitoba: Queen's Printer,

individualized assessment of capacity that recognizes “the ability of older youths to make decisions respecting their health and welfare.”³²

Notwithstanding these statements of legislative intent, the Manitoba Court of Appeal held, in 2007, in *Manitoba (Director of Child & Family Services) v. C.(A.)*, that under Manitoba's *Child and Family Services Act*, sections 25(8) and 25(9) supersede both the common law respecting medical consent by mature minors and provincial consent to treatment legislation, thereby authorizing a court to overrule treatment decisions of a capable minor who is under sixteen and, therefore, by statutory definition, a child.³³ The Court of Appeal went on to find that the impugned sections of Manitoba's *Child and Family Services Act* did not unjustifiably violate the young woman's rights under sections 2(a), 7 and 15(1) of the *Canadian Charter of Rights and Freedoms (Charter)*. The Supreme Court of Canada has since granted leave to appeal in *C.(A.)*.³⁴

3) Jurisdictions Where Capable Young Persons May Make Treatment Decisions in Their “Best Interests”

In New Brunswick, Quebec and British Columbia, provincial consent to treatment legislation reflects the common law to varying degrees. All three provinces permit capable minors above legislatively-set ages to decide their own medical treatment. Even below those ages, however, the young person is permitted to decide her or his medical treatment if the treatment decision is considered by the treating doctor to be in the young person's “best interests.”

In *Walker (Litigation Guardian of) v. Region 2 Hospital Corp.*,³⁵ the majority of the New Brunswick Court of Appeal, sitting *en banc*, held that at common law a mature minor has the “legal capacity to consent to his or her own treatment,” including “the right to refuse treatment.”³⁶ The Court noted that New Brunswick's *Medical Consent*

1991) at 13-14 [MLRC, *Self-Determination*]; Manitoba, “Report of *The Mental Health Act* Review Committee” (January 1997) at 24.

³² Manitoba, Legislative Assembly, Standing Committee on Law Amendments in *Debates and Proceedings (Hansard)*, Vol. 48, No. 9 (22 June 1998), time 2150.

³³ *Manitoba (Director of Child & Family Services) v. C.(A.)*, 2007 MBCA 9, 276 D.L.R. (4th) 41 at 47, 66 [C.(A.)]. The author of this article was counsel for C.(A.) in the Manitoba Court of Appeal.

³⁴ S.C.C. File No. 31955, online: <http://cases-dossiers.scc-csc.gc.ca/information/cms/docket_e.asp?31955, 25 October 2007>. The author of this article is counsel for C.(A.) in Supreme Court of Canada.

³⁵ (1994), 4 R.F.L. (4th) 321 (N.B.C.A.) [*Walker*].

³⁶ *Ibid.* at 333-36.

of *Minors Act*³⁷ codifies the common law to the extent that health care decisions of capable persons aged sixteen or older are treated “in the same manner as if they had attained the age of majority.” For persons under sixteen, the Act modifies the common law so that the capable minor’s treatment decision will not necessarily be disregarded, unless two physicians agree the recommended treatment is in the minor’s best interests.

In British Columbia, the *Infants Act*³⁸ and the *Child, Family and Community Service Act*³⁹ bear on a young person’s medical treatment decisions. Section 17 of the *Infants Act*, for example, provides that a capable person under nineteen, the legislated age of majority, “may consent to health care” and that a health care provider will not be held liable in battery if she or he believes the young person is capable and the medical treatment is in the young person’s “best interests.”⁴⁰

In *Ney v. Canada (A.G.)*, Huddart J. held that the *Infants Act* “does no more than affirm [the] common law ‘mature minor’ rule.”⁴¹ The Act’s provision that the recommended health care be in the young person’s best interests was added, not to modify the common law, but to “reduce the risk of a civil action” against the health care provider.⁴² In *obiter*, Huddart J. expressed the view the state—through the legislature (as, for example, in the *Child, Family and Community Services Act*)—and superior courts, in exercise of their *parens patriae* jurisdictions, may override the treatment decision of a capable person under nineteen.⁴³ To the contrary, as the author discusses below, the *parens patriae* jurisdiction cannot be exercised over a capable person of any age.

In *Van Mol (Guardian ad litem of) v. Ashmore*, a malpractice action, the British Columbia Court of Appeal agreed that the *Infants Act* does not modify the common law “mature minor” rule.⁴⁴ Adopting the New

³⁷ *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1.

³⁸ *Infants Act*, R.S.B.C. 1996, c. 223.

³⁹ *Child, Family and Community Service Act*, R.S.B.C. 1996, c. 46. British Columbia’s *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, which prohibits health care being given to a person without that person’s consent, applies only to treatment decision of an adult, defined as a person 19 years of age and older.

⁴⁰ *Infants Act*, *supra*, note 38 at s. 17.

⁴¹ (1993), 102 D.L.R. (4th) 136 at 147 (B.C.S.C.).

⁴² *Ibid.* at 142.

⁴³ *Ibid.* at 146.

⁴⁴ 1999 BCCA 6, (1999)168 D.L.R. (4th) 637 at 668, leave to appeal to S.C.C. refused [1999] S.C.C.A. No. 117 [*Van Mol*].

Brunswick Court of Appeal's decision in *Walker*,⁴⁵ the Court held that, once a young person has achieved consenting capacity, "[a]ll rights in relation to giving or withholding consent will then be held entirely by the child," entitling the capable young person to be treated at law "in the same way that any person of full age and capacity should [be] treated."⁴⁶

However, in *B.(S.J.) (Litigation Guardian of) v. British Columbia (Director of Child, Family and Community Service)*, Boyd J. of the British Columbia Supreme Court concluded that the common law treatment decision right of a capable person under nineteen is superseded by section 29 of British Columbia's *Child, Family and Community Service Act*. Boyd J. reasoned that section 29 of the Act empowers the state to override a capable young person's treatment decision and authorize a medical procedure the court believes is in the young person's "best interests."⁴⁷ As a result, the capable minor in *B.(S.J.)* was forced to transfer her medical care to Schneider Children's Hospital in Long Island, New York, at her own expense. There, her decision to receive mainstream medical treatment for her cancer, without blood transfusions, was respected. As a condition of permitting B.(S.J.), by then fifteen years old, to transfer her care to New York, the Attorney General of British Columbia required the young woman to abandon her appeal of Boyd J.'s decision.⁴⁸

⁴⁵ *Walker*, *supra* note 35.

⁴⁶ *Supra* note 44 at 663, 669, 676.

⁴⁷ *B.(S.J.) (Litigation Guardian of) v. British Columbia (Director of Child, Family and Community Service)*, 2005 BCSC 573, (2005) 42 B.C.L.R. (4th) 321 at paras. 70, 78, 90 (B.C.S.C.) [*B.(S.J.)*].

⁴⁸ *Ibid.* at para. 70. See the decision of the Ontario Court of Appeal in *B.(S.J.) Ont.*, *supra* note 26 at paras. 2-4, 6, 22-32 which recounts the events subsequent to Boyd J.'s decision in *B.(S.J.)*, *supra* note 48. (The author of this article was one of B.(S.J.)'s solicitors.) Following dismissal of her appeal by Boyd J. in British Columbia, B.(S.J.) sought second opinions and possible treatment for her cancer in Toronto, Ontario, and Long Island, New York, during a window in her cancer treatment. While she was in Ontario, the Director obtained from Boyd J. an *ex parte* custody order over her, requiring her to return to British Columbia where she faced the prospect of receiving forced blood transfusions contrary to her religious conscience. The Director then obtained, again *ex parte*, an order from Mesbur J. of the Ontario Superior Court of Justice enforcing Boyd J.'s *ex parte* custody order. Paisley J. refused B.(S.J.)'s *inter partes* application to set aside Mesbur J.'s order. After being arrested and escorted, in custody, back to British Columbia, she eventually obtained necessary mainstream medical treatment for her cancer without blood transfusions at Schneider Children's Hospital in Long Island, New York, but only after first being required by the British Columbia Director and Attorney General to abandon her appeal of Boyd J.'s original decision. She later appealed the decisions of Mesbur J. and Paisley J. to the Ontario

In Quebec, the *Civil Code* sets fourteen as the minimum age for valid consent by a young person to medical treatment. The Quebec Superior Court, however, is authorized to override a minor's refusal of a medical procedure that the court considers to be in the minor's best interests.⁴⁹ It is unclear what weight a court would accord the capacity of a minor in assessing her or his best interests.

4) Jurisdictions that Prescribe an Arbitrary Age for Medical Consent

Saskatchewan⁵⁰ sets sixteen as the minimum legislated age to make a health care directive. In Alberta, the prescribed age is eighteen.⁵¹ Absent contemporaneous or advance consent-to-treatment legislation governing persons under the age of majority, the author argues, the common law "mature minor" rule should apply. Judicial consideration of that prospect, however, has not been consistent.

In *Re Dueck*, Rothery J. of the Saskatchewan Court of Queen's Bench ruled that the state's authority to intervene in the treatment decisions of a minor is equivalent to the authority of a parent or guardian. If the young person is found capable of deciding her or his medical treatment, then the "Minister's consent is no longer required, the same way that the parent's consent would no longer be required." The capable young person "is entitled" to give or refuse consent to her or his medical care.⁵²

In *U.(C.) (Next Friend of) v. Alberta (Director of Child Welfare)*, the Alberta Court of Appeal reached the opposite conclusion. The Court of Appeal agreed that a court is "unable to exercise its *parens patriae* jurisdiction with respect to a capable minor who is no longer in need of protection from the court."⁵³ Nonetheless, it held that provincial legislatures possess a "general jurisdiction" (independent, that is, of their *parens patriae* jurisdiction) to "enact laws with respect to [a capable minor] to the same extent that it may legislate with respect to its adult subjects."⁵⁴ The Court further held that Alberta's *Child Welfare*

Court of Appeal. Her appeal was allowed. The Ontario Court of Appeal held the British Columbia Director's actions and the orders of Boyd J. in British Columbia, and Mesbur J. and Paisley J. in Ontario had each deprived B.(S.J.) of the "fair *inter partes* hearing to which [she] was entitled"; see *B.(S.J.) Ont.*, *ibid.* at 549.

⁴⁹ *Civil Code of Quebec*, S.Q. 1991, c. 64, ss. 14, 16.

⁵⁰ *The Health Care Directives and Substitute Health Care Decision Makers Act*, S.S. 1997, c. H-0.001, s. 3.

⁵¹ *Personal Directives Act*, R.S.A. 2000, c. P-6, s. 3(1).

⁵² *Re Dueck* (1999), 171 D.L.R. (4th) 761 at 764-65, 767 (Sask. Q.B.).

⁵³ 2003 ABCA 66, (2003) 223 D.L.R. (4th) 662 at 674 [*U.(C.)*]. The author of this article was counsel for U.(C.).

⁵⁴ *Ibid.*

*Act*⁵⁵ (under which a person is a child up to eighteen years old) was a valid exercise of that “general jurisdiction.”⁵⁶ The Court elected not to decide whether the Act unjustifiably infringes the *Charter* rights of capable persons under the age of eighteen.⁵⁷

c) Issues Raised

What, then, is a doctor to do, or a lawyer to advise, in Canada, when presented with treatment instructions of a capable young person? Should the doctor rely on the instructions of the capable young person at common law or to the extent provincial or territorial legislation authorizes, or must the doctor contact child welfare authorities? What does the law require? And, in identifying applicable law, what about the young person’s constitutional rights to liberty, security of the person, freedom from discrimination, and freedom of religious conscience under sections 7, 15(1) and 2(a) of the *Charter*? Does a capable young person possess *Charter* rights to make medical treatment decisions? If so, is the exercise of those *Charter* rights dependent on province or territory of residence? These questions will next be addressed.

3. Common Law Recognition of Treatment Decision Rights of Capable Young Persons

a) Common Law Rights of Persons Generally

Common law generally recognizes that each person—whether an adult or mature minor—has the inviolable right to decide whether to give or refuse consent to a particular medical treatment. Legal validity of the treatment decision requires the decision to have been made voluntarily—unaffected by undue influence, misrepresentation or duress—by the affected patient, relying on adequate medical information and advice about the treatment’s basic nature. The patient must be capable of appreciating the nature and reasonably foreseeable consequences (including risks and benefits) of the particular involved treatment. The capable patient must voluntarily communicate the decision to her or his treatment provider.⁵⁸ The decision may, depending on the illness and its progress, amount to entirely or partially accepting the treatment-provider’s recommendation; choosing and

⁵⁵ *Child Welfare Act*, R.S.A. 2000 c. C.-12, now the *Child, Youth and Family Enhancement Act*, R.S.A. 2000, c. C-12.

⁵⁶ *U.(C.)*, *supra* note 53 at 674.

⁵⁷ *Ibid.* at 670.

⁵⁸ Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Scarborough: Carswell, 2007) at 56-99.

authorizing alternative treatment (although a doctor is entitled to refuse to provide that treatment); or perhaps declining treatment.

Capacity, consent and voluntariness are therefore critical to a patient making decisions about medical treatment.

1) Capacity

The terms “capacity” and “competency” to make medical treatment decisions are interchangeable, describing the mental ability to perform a particular task or tasks. Provincial health care legislation usually employs the term “capacity” to avoid the pejorative connotation that is sometimes associated with the term “incompetent.”⁵⁹

Capacity is task-specific.⁶⁰ A person may be capable to perform a particular task, yet unable to perform another. Capacity is also individual-specific. A person is not incapable simply because of age or because others may find the person’s choices “disagreeable or difficult to understand.”⁶¹ An assessment of capacity must focus on that person, including assessment of the person’s own “considered or habitual standards or goals”⁶² rather than on judgment of the person’s choices “according to a conventional standard.”⁶³

The Supreme Court of Canada’s reasons in *Starson v. Swayze*⁶⁴ summarize the legal definition of capacity.⁶⁵ Treatment may be imposed on a person “[o]nly where it can be shown that a person is unable to understand relevant factors and appreciate the reasonably foreseeable consequences of a decision or lack of decision.”⁶⁶

Ability to “understand” the treatment recommendation or decision means the patient “must be capable of intellectually processing the information as it applies to his or her treatment, including its potential

⁵⁹ See generally Hoffman, *supra* note 18 at 1; *Gillick v. West Norfolk and Wisbech Area Health Authority*, [1985] 3 All E.R. 402 at 423 (H. L.) [*Gillick*].

⁶⁰ Michel Silberfeld and Arthur Fish, *When the Mind Fails: A Guide to Dealing with Incompetency* (Toronto: University of Toronto Press, 1994) at 4.

⁶¹ *Ibid.* at 47.

⁶² *Ibid.* at 48.

⁶³ *Ibid.* at 6.

⁶⁴ *Supra* note 15.

⁶⁵ While *Starson, ibid.*, concerned application of Ontario’s *Health Care Consent Act*, it is generally recognized that the *Act* codified the common law and thus the decision is persuasive throughout Canada.

⁶⁶ *Ibid.* at para. 10.

benefits and drawbacks.” This does not mean the patient must agree “with a medical professional’s diagnosis *per se*.”⁶⁷

Ability to “appreciate” the consequences of the treatment decision includes appreciating available information on the nature and purpose of the proposed treatment, the potential benefits and risks, alternatives available and the expected consequences of not having treatment. While actual appreciation is desirable, it is not legally required; the patient need only have the *ability* to appreciate. The failure of the treating doctor or anyone else to explain adequately to a patient the anticipated consequences of particular treatments thus does not deprive the patient of the legal right to autonomously make the decision about treatment, provided she or he has the capacity to do so.⁶⁸

As held in *Starson*, the best interest test, an expression of legislative and judicial *parens patriae* jurisdiction,⁶⁹ does *not* apply to override the medical treatment decisions of a capable person.⁷⁰ Otherwise, a capable person’s dignity and autonomy—integral to coping with, and challenging, an illness—would be illusory.

2) Consent

Common law has long recognized that an intentional unwanted “touching of another” is actionable in tort as a battery.⁷¹ In medical treatment law, any treatment without consent is battery if administered, without a patient’s contemporaneous consent while the patient is capable, or, alternatively, without the substitute consent of someone else who is (1) permitted at common law (such as a personal guardian of an incapable young person, or under substitute consent or dependent adults legislation); (2) required (under court-sanctioned guardianship, for example); or (3) authorized (such as under a statutory advance medical directive, or a proxy appointment) to consent on the patient’s behalf. Consent to treat is not required by a doctor in emergencies necessitating immediate treatment of a patient to preserve health or life, or where a patient, due to unconsciousness or extreme illness, is unable to consent, provided, in any of these circumstances, the patient is lacking a valid and accessible advance health care directive.⁷²

⁶⁷ *Ibid.* at paras. 16, 80.

⁶⁸ *Ibid.* at paras. 80-81.

⁶⁹ *Eve*, *supra* note 4 at 426.

⁷⁰ *Starson*, *supra* note 15 at paras. 19, 75, 112.

⁷¹ *Cole v. Turner*, (1704) 6 Mod. 149, Holt C.J.; see generally *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.) [*Fleming*].

⁷² Linda D. Rainaldi, ed., *Remedies in Tort*, vol. 1, looseleaf (Toronto: Carswell, 1987) at 2-45 § 36; Picard and Robertson, *supra* note 58.

Although facially a contradiction in terms, the consent of the patient must be informed, rather than being “informed consent.” As explained by Ellen I. Picard and Gerald B. Robertson in their seminal work *Legal Liability of Doctors and Hospitals in Canada*:⁷³

The term “informed consent” is now familiar to most laypeople and health professionals alike, but many writers and the Supreme Court of Canada [in *Reibl v. Hughes* (1980), 114 D.L.R. (3d) 1 at 8-9] have suggested that it is a phrase which ought to be avoided because of its ambiguity. The problem is that its use may lead to “uninformed consent” being equated with “invalid consent”; in other words, one may conclude that consent is not valid unless the patient is properly informed. . . . Reibl firmly establishes that doctors have a legal duty to advise their patients of the material risks (and other material information) associated with proposed treatment prior to obtaining consent. However, in Reibl the Supreme Court of Canada also held that failure to provide this information to the patient may render the doctor liable in negligence, but it does not vitiate the consent so as to make the doctor liable in battery. Thus, “uninformed” consent does not mean “invalid” consent.

In *Ciarlariello v. Schacter*, Cory J. held that “[e]veryone has the right to decide what is to be done to one’s own body. This includes the right to be free from medical treatment to which the individual does not consent.”⁷⁴ Robins J.A. for the Ontario Court of Appeal in *Fleming v. Reid* observed that the right to bodily integrity is “deeply rooted in our common law.”⁷⁵ He added: “[E]very person’s body is considered inviolate. . . . The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment—any treatment—is to be administered.”⁷⁶

3) *Voluntariness*

Consent to treatment can be vitiated if not given voluntarily.⁷⁷ Voluntariness has little application to the present discussion. It generally arises in negligence cases where a patient claims, after the fact, that she or he did not provide a valid consent to a particular treatment.⁷⁸

⁷³ Picard and Robertson, *ibid.* at 98.

⁷⁴ *Ciarlariello*, *supra* note 15 at 135.

⁷⁵ *Fleming*, *supra* note 71 at 85.

⁷⁶ *Ibid.*; see also *Malette v. Shulman* (1990), 72 O.R. (2d) 417 at 423 (C.A.); *Allan v. New Mount Sinai Hospital*, (1980), 109 D.L.R. (3d) 634 at 642 (Ont. H.C.), *rev’d on other grounds* (1981), 125 D.L.R. (3d) 276 (C.A.).

⁷⁷ *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 at 250.

⁷⁸ See generally, Lorne E. Rozovsky, *The Canadian Law of Consent to*

As an ingredient of treatment decision-making, voluntariness is articulated, generally, by Picard and Robertson:

While it is true that consent must be the result of freedom of choice, an anxious, ill person, often with a concerned family hovering and advising, will be unable to make a decision without some degree of fear, constraint or duress. However, it is usually easy to identify the extreme cases in which the persuasion and influence of others is so extensive that the patient's decision cannot truly be described as free and voluntary. If a doctor has reason to believe that the consent was given because the patient felt fear or compulsion from others, the doctor should discuss the matter with the patient alone.⁷⁹

Where alleged that the purported consent of a capable young person to treatment is not voluntary, and is therefore invalid, considerable caution must be exercised in ascertaining that the allegation is not a proxy for intolerance, as may be the case, for example, when the young patient, on the basis of unpopular religious beliefs, consents only to an alternative to a treatment-provider's recommended medical procedure.

4. Determining Capacity, Consent, and Voluntariness

Since 1987, the author has represented numerous capable young persons, some of whom were before the courts at the instance of a child welfare director because of their decisions not to consent to blood transfusions recommended as essential or preferable by their medical treatment providers. Aware of the concern that a young person, like any client, could possibly be inappropriately influenced by immediate family, other relatives, friends or spiritual advisors, the author faithfully employs a protocol designed (1) to reasonably ensure the young person is legally capable to give consent that is informed and voluntary, and although not generally germane to legal capability, (2) to identify the capable, informed and voluntary treatment decisions.

Treatment, 2d ed. (Toronto: Butterworths, 1997) at 19-21; Barney Sneiderman, John Irvine and Philip H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and Our Health Care Professionals*, 2d ed. (Scarborough: Carswell, 1995) at 33; and Sarita Verma, "Competency and Decision-Making Capacity" (1995) 12 *Law Soc'y Gaz.* 252.

⁷⁹ Picard and Robertson, *supra* note 58 at 62. The authors, at 64, also identify medication, and the setting and immediacy of a medical procedure, as factors which may "militate against a patient being able to make a free or voluntary [treatment] decision", thus heightening the importance of the duty of the treating physician to make every effort "to obtain consent in a non-coercive environment from a patient whose judgment is not affected by medication."

Initially, and expeditiously, based on hospital charts and information from health care providers, the author briefs himself about the young person's illness and its history; ensures the mental status and medications of the person do not pose impediments to receiving legal advice, and learns about treatment preferences she or he is pondering. Then the author conducts consultations with the young person alone.

In consulting with the young person—a process involving not more than a couple of hours—positive rapport is established. Effective communication is developed. The life experience of the young person, including the impact of the illness, is scrutinized. Her or his adequate understanding of the illness is confirmed. The illness's potential for influencing treatment decision-making is identified. Adequacy of medical information and advice is determined. Independence of treatment decision-making by the young person, absent inappropriate pressures and influences, is ascertained. Circumstances impairing the person's freedom to make treatment decisions are eliminated. Intellectual and cognitive capacity to understand—and actual understanding of—the nature, gravity, purpose, course, and probable benefits and risks of treatment proposed by health care providers are explored, as are the prospects of harm from treatment options desired by the young person. Ability to think abstractly and to appreciate (that is, understand inferentially) the possible consequences of the desired treatment—and indications the young person is doing so—are discussed; this includes discussion of whether and, if so, why factors regarded by health care providers as being unrelated to treatment—such as religious conscience—are important to the young person in treatment decision-making. The young person is made aware that, ultimately, his or her capacity to choose treatment (although not the treatment choice itself) may if a court is involved become a legal rather than a medical decision. It should be noted that if a court convenes in the young person's hospital room, the judge presiding usually makes these same inquiries of the young person.

Recognizing the limitations of a lawyer's professional training and experience, the author enlists assistance of a psychologist or psychiatrist and a physician in undertaking these inquiries.

Whether satisfied or uncertain that the young person is legally capable of making decisions about treatment of the involved illness, the author arranges for an independent psychiatric assessment of the young person's capacity, for the benefit of himself (in advising the person), and of the court (if involved), should such assessment not already have been competently conducted on behalf of the person's treatment providers.

Only if and when satisfied the young person is capable (as in the case of any client), will the author obtain instructions. Instructions (and their rationale) are obtained directly from the young person, usually in writing, concerning his or her treatment choices. Instructions are never accepted from (or discussed with) the young person's parents, other relatives, friends or spiritual advisers, who are perceived by the author as confined to being sources of significant moral support.

By assiduously following this protocol, the author's experience is that where he has satisfied himself that the young person possesses legal capacity, courts often reach the same conclusion, deciding that the young person is independently capable of voluntarily giving or refusing informed consent to medical treatment recommended by her or his treatment-provider, or of voluntarily giving informed consent to alternative treatment she or he has requested. The author has never encountered a capable young person who refused all treatment.

If a court were to conclude that a young person's treatment decision was not informed, or was not voluntary, the remedy should not be an order, based on an application by the state, authorizing imposed treatment on the patient.⁸⁰ Rather, the treating doctor should again explain to the capable young patient the nature of the treatment contemplated, its benefits and risks, and the alternatives. It is then for that patient, adequately informed, to decide whether to consent to the proposed treatment or choose alternative treatment.

b) Parens Patriae Protection of Incapable Persons

1) Origins and Historic Development of Parens Patriae Before 1867

Authority for common law and legislative protection of persons not capable of deciding their medical treatment originates in *parens patriae*. Sir Henry Theobald surmises the most probable genesis of *parens patriae*:

Either by general assent or by some statute, now lost, the care of persons of unsound mind was by Edw. 1 [1272-1307] taken from English feudal lords, who would naturally take possession of the land of a tenant unable to perform his feudal duties.⁸¹

⁸⁰ *Starson*, *supra* note 15 at paras. 14, 81.

⁸¹ Sir Henry Studdy Theobald, *The Law Relating to Lunacy* (London: Stevens and Sons Ltd., 1924) at 1, cited by La Forest J. in *Eve*, *supra* note 4 at 407. See also A.T. Carter, *A History of English Legal Institutions*, 4th ed. (London: Butterworth & Co., 1910) at 46; Verma, *supra* note 78 at 257.

Historically *parens patriae* grew from the sovereign's concern for the protection of mentally-ill subjects, not the welfare of children (unless they were of unsound mind).

In the 1540s, *parens patriae* jurisdiction over persons legally lacking capacity due to unsound mind was transferred from England's sovereign to a tribunal known as the Court of Wards and Liveries.

Meantime, another species of jurisdiction—wardship of children incapable due to age—developed quite separately from *parens patriae*. The jurisdiction initially rested on the view that custody of children was a property right, which originated in the feudal system of tenures. La Forest J. explains in *Eve*: “The original purpose of the wardship jurisdiction was to protect the [property] rights of the guardian rather than of the ward.”⁸² The Court of Wards and Liveries administered the wardship jurisdiction, in addition to *parens patriae* jurisdiction governing persons of unsound mind.

About the 1660s, the Court of Wards and Liveries was abolished. Its jurisdiction—*parens patriae* and wardship—was assumed by the Court of Chancery (Lord Chancellor). In that Court, child wardship effectively merged in and expanded the *parens patriae* jurisdiction. The resulting jurisdiction, as described by the Lord Chancellor in 1827:

... belongs to the King as *parens patriae*, having the care of those who are not able to take care of themselves, and is founded on the obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is clear that some care should be thrown round them.⁸³

The next year, a member of the House of Lords in *Wellesley v. Wellesley* “resembled the [*parens patriae*] jurisdiction over infants, to the care which the Court takes with respect to lunatics.”⁸⁴

As expressed by the Court of Appeal of England and Wales, specifically in relation to children, “the court would do what in the circumstances a *wise parent* acting for the true interests of the child would or ought to do,”⁸⁵ under its *parens patriae* authority.

⁸² *Eve*, *ibid.* at 407.

⁸³ *Wellesley v. Duke of Beaufort* (1827), 2 Russ. 1, 38 E.R. 236, quoted in *Eve*, *ibid.* at 410.

⁸⁴ 2 Bli. N.S. 124 at 131, 4 E.R. 1078 at 1081, quoted in *Eve*, *ibid.* at 411.

⁸⁵ *Re Z (A Minor)*, [1995] E.W.J. No. 5787 at para. 7 (C.A.) (QL) [emphasis added].

While “the scope or sphere of operation of *parens patriae* jurisdiction may be unlimited,” La Forest J. cautioned in *Eve* that:

. . . it by no means follows that the discretion to exercise it is unlimited. It must be exercised in accordance with its underlying principle. Simply put, the discretion is to do what is necessary for the protection of the person for whose benefit it is exercised. . . . The discretion is to be exercised for the benefit of that person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases. This is particularly so in cases where a court might be tempted to act because failure to do so would risk imposing an obviously heavy burden on some other individual.⁸⁶

Parens patriae jurisdiction appears to first have been adopted—legislatively—in Canada in 1848. Prince Edward Island’s *Chancery Act* “substantially reproduced the law as it had existed for many years” in England.⁸⁷ As summarized by La Forest J.:

[In] the case of idiots, mentally incompetent persons or persons of unsound mind, and their property and estate, the jurisdiction of the [Chancery] Court shall include that which in England was conferred upon the Lord Chancellor by a Commission from the Crown under the Sign Manual, except so far as the same are altered or enlarged as aforesaid.⁸⁸

Presumably “mentally incompetent persons” included children who lacked capacity due to age.

With proclamation of the *Constitution Act, 1867*, *parens patriae* jurisdiction was recognized as part of the law throughout Canada. Section 129 of the *Constitution Act, 1867* provides for each provincial legislature to retain its own body of laws, including “the laws ‘received’ from England,”⁸⁹ which included *parens patriae* authority.

2) Modern Application of *Parens Patriae* Since 1867

i) *Judicial Limits*

Subsequent application of the *parens patriae* jurisdiction—judicially—has reflected its mandate, described by the Lord Chancellor in 1827 and

⁸⁶ *Eve*, *supra* note 4 at 427.

⁸⁷ *Ibid.* at 409.

⁸⁸ *Ibid.*

⁸⁹ See Peter W. Hogg, *Constitutional Law of Canada*, 5th ed. vol. 1, looseleaf (Scarborough: Carswell, 1997) at 2-11.

echoed by La Forest J. in 1986.⁹⁰ The jurisdiction has been confined by courts to persons who cannot care for themselves.

In *Fleming*, adopted by the Supreme Court in *Starson*,⁹¹ the Ontario Court of Appeal held that *parens patriae* jurisdiction cannot be judicially invoked to deprive capable patients—who, the author submits, include capable minors—“of rights expressly granted by statute or to abrogate their *Charter* rights.”⁹² Robins J.A. explained:

The *parens patriae* jurisdiction was intended to operate only where a person is unable to take care of himself or herself. It cannot be exercised by the state to overrule a treatment decision made by a competent patient, who, by definition, is able to direct the course of his or her medical care, regardless of the fact that the decision may be considered, by objective standards, medically unsound or contrary to the patient’s best interests.⁹³

ii) Legislative Limits

In *U.(C.)* the Alberta Court of Appeal held that the legislature’s power to enact laws respecting “minors does not flow from a *parens patriae* jurisdiction comparable to that of a court of inherent jurisdiction; rather it forms part of the legislature’s general jurisdiction to enact laws affecting its subjects.”⁹⁴ This conclusion, if meant to apply to child welfare legislation, must surely be in error. As stated by the Supreme Court of Canada in *New Brunswick (Minister of Health) v. G.(J.)*, the legislature’s power to enact child welfare legislation is “pursuant to the state’s *parens patriae* jurisdiction.”⁹⁵ It follows that the legislature’s *parens patriae* jurisdiction over a child—such as when child protection in relation to medical treatment is involved—like that of superior courts of inherent jurisdiction, is limited to the authority of the child’s personal guardian(s), and ceases at the time, and to the extent, that a

⁹⁰ See *Beson v. Director of Child Welfare (Nfld.)*, [1982] 2 S.C.R. 716. The author of this article was counsel for the five-year-old child, by appointment from Supreme Court of Canada.

⁹¹ *Starson*, *supra* note 15.

⁹² *Fleming*, *supra* note 71 at 91.

⁹³ *Ibid.*; *Starson*, *supra* note 15 at para. 75. The New Brunswick Court of Appeal in *Walker*, *supra* note 35 at 334-35, applied *Fleming* in ruling that *parens patriae* jurisdiction does not apply to mature minors who, by definition, are “able to take care of himself or herself.” See also *Winnipeg Child and Family Services (Northwest Area) v. G.(D.F.)*, [1997] 3 S.C.R. 925 at 954 [*G.(D.F.)*].

⁹⁴ *Supra* note 53 at 674.

⁹⁵ [1999] 3 S.C.R. 46 at paras. 61, 70. See also: *G.(D.F.)*, *supra* note 93 at 954-60; *B.(R.)*, *supra* note 2 at paras. 88, 116; *Winnipeg Child & Family Services (Central Area) v. W.(K.L.)*, 2000 SCC 48, [2000] 2 S.C.R. 519 at 537, 564.

young person achieves consenting capacity to make medical treatment decisions.

If the *parens patriae* jurisdiction of superior courts ceases once a minor achieves consenting capacity, as accepted by the Alberta Court of Appeal in *U.(C.)*⁹⁶ and the New Brunswick Court of Appeal in *Walker*,⁹⁷ it follows that the *parens patriae* jurisdiction of the legislature also then comes to an end.

The Alberta Court of Appeal is incorrect to assert that the provincial legislature possesses a “general jurisdiction,” presumably under section 92(13) of the *Constitution Act, 1867*, to override the treatment decisions of capable young persons and adults. The Supreme Court of Canada has consistently held the right to the inviolability of one’s person is an “original freedom,” a civil right that cannot be abolished by provincial or territorial legislation. Professor Hogg maintains:

The term “civil rights” in s. 92(13) is used in the older, stricter sense. It does not include the fundamental civil liberties of belief and expression. Of course, many provincial laws impinge on those civil liberties, but a law whose pith and substance is the restraint of belief or expression does not come within property and civil rights in the province.⁹⁸

Professor Frank R. Scott observed:

The civil rights of 92-13 do not include the general concept of civil liberties and fundamental freedoms even in so far as the province itself is concerned; a fortiori they have nothing to do with the civil liberties and fundamental freedoms of Canadians as citizens of the Canadian nation.⁹⁹

Therefore, to the extent provincial legislation purports to interfere with treatment decisions of capable adults or mature minors such legislation is *ultra vires*.¹⁰⁰

⁹⁶ *U.(C.)*, *supra* note 53 at 674.

⁹⁷ *Walker*, *supra* note 35 at 334-35.

⁹⁸ Hogg, *supra* note 89 at 21-2 to 21-4.

⁹⁹ Frank R. Scott, “Dominion Jurisdiction Over Human Rights and Fundamental Freedoms” (1949), 27 *Can. Bar Rev.* 497 at 509; see also *Saumur v. Quebec (City of)*, [1953] 2 S.C.R. 299 at 329.

¹⁰⁰ In *B.(S.J.)*, *supra* note 47 at para. 78, Boyd J. of the British Columbia Supreme Court expressed her opinion that s. 29 of British Columbia’s *Child, Family and Community Services Act* (as applied to capable minors) fell within provincial jurisdiction under s. 92(16) of the *Constitution Act, 1867*. Section 92(16) confers on

c) *Common Law Rights of Capable Young Persons*

1) *Overview*

The common law has always recognized the rebuttable presumption that persons of any age are capable of making their own medical treatment decisions. The presumption is rebutted regarding young children for the obvious reason that their cognitive immaturity generally precludes their treatment choices from being reliably depended upon by health care-givers; in which event their personal guardians give consent.¹⁰¹ Not all children, however, lack capacity to make treatment decisions. “Given that most adolescents [i.e., children from about 14 years old] have the capacity necessary to make competent health care decisions, the ethical physician should respect this and allow the competent adolescent the right to exercise autonomy” to choose her or his treatment, conclude Dr. Christopher Doig and Dr. Ellen Burgess.¹⁰²

The common law respects the treatment decisions of capable adolescents, referring to them as “mature minors.” The term, an alliterative phrase of convenience to describe a young person capable of deciding her or his medical treatment, has been judicially elevated to the status of a common law rule.¹⁰³ The necessity for a “mature minor” rule is doubtful, considering that the term serves simply to reinforce the common law’s rebuttable presumption of capacity (i.e., rebuttable by a young person from seven to fourteen years of age, and by the state from fourteen to twenty-one years old).

The Law Reform Commission of Alberta in *Consent of Minors to Health Care* observes: “In England and Canada there never was a rigid

provincial legislatures power to make laws in relation to “all matters of a merely local or private nature in the province.” Hogg, in *supra* note 89 at 32-1 to 32-2, explains that s. 92(16) is largely subsumed by s. 92(13) (“property and civil rights in the province”) and is the “source of provincial authority over some matters of *public health*,” such as the compulsory treatment of drug addicts or legislation permitting the confinement of a mentally ill person for the protection of the public [emphasis added]. As with s. 92(13) of the *Constitution Act, 1867*, s. 92(16) does not confer on provincial Legislatures authority to impose an unwanted medical procedure on a capable patient who does not pose a threat to “public health.”

¹⁰¹ See results of Jean Piaget’s research into children’s cognitive development in Christopher Doig and Ellen Burgess, “Withholding Life-Sustaining Treatment: Are Adolescents Competent to Make These Decisions?” (2000) 162:11 C.M.A.J. 1585 at 1585-86.

¹⁰² *Ibid.* at 1587.

¹⁰³ For example, see *Hewer v. Bryant*, [1970] 1 Q.B. 357 (C.A.) [*Hewer*].

rule that the consent of parent or guardian is always necessary to medical treatment of a minor.”¹⁰⁴ Similarly, the Manitoba Law Reform Commission in *Minors' Consent to Health Care* states, “Common sense and common practice dictate that parental consent should not be necessary in respect of all medical treatment of all minors. . . . [T]he law has sought to draw a distinction between minors who have the capacity to consent to health care and those who do not.”¹⁰⁵

2) “Mature Minors” (*Capable Young Persons*)

i) *Judicial Development*

While the Rule of Sevens was recognized in England by at least the mid 1700s,¹⁰⁶ it was not until 1970 that a Canadian court was first asked to rule whether an “unemancipated minor” —that is, a person under twenty-one years old—may consent to medical treatment.

In *Johnston v. Wellesley Hospital*, the twenty-year-old minor consented to a dermatological operation to remove acne scars. Addy J. for the Ontario High Court held that parental consent for the operation was unnecessary:

[I]t would be ridiculous in this day and age . . . to state that a person of 20 years of age, who is obviously intelligent and as fully capable of understanding the possible consequences of a medical or surgical procedure as an adult [a person who, at common law, is 21 years or older], would, at law, be incapable of consenting thereto.¹⁰⁷

The same year, in *Hewer v. Bryant*, Lord Denning rejected the idea a minor could not consent to medical care.¹⁰⁸ He overruled *In re Agar-*

¹⁰⁴ Alberta, Institute of Law Research and Reform, *Consent of Minors to Health Care*, Report No. 19, (Edmonton: University of Alberta, 1975) at 3.

¹⁰⁵ MLRC, *Minors' Consent*, *supra* note 30 at 3.

¹⁰⁶ Blackstone's *Commentaries on the Laws of England*, Book IV, 1st ed. (1769), at 23-24: “But by the law, as it now stands, and has stood at least ever since the time of Edward the third, the capacity of doing ill, or contracting guilt, is not so much measured by years and days, as by the strength of the delinquent's understanding and judgment. For one lad of eleven years old may have as much cunning as another of fourteen; and in these cases our maxim is that ‘malitia supplet aetatem’ . . . [U]nder fourteen, though an infant shall be prima facie adjudged to be *doli incapax*; yet if it appear to the court and jury, that he was *doli capax*, and could discern between good and evil, he may be convicted and suffer death.” See also *R. v. Smith*, 1 Cox C.C. 260 (1845); *Re C. (A Minor)*, [1995] H.L.J. No. 9 at paras. 11-12, 50 (QL).

¹⁰⁷ *Johnston v. Wellesley Hospital* (1970), 17 D.L.R. (3d) 139 at 144 (Ont. H.C.).

¹⁰⁸ *Supra* note 103.

Ellis,¹⁰⁹ the nineteenth-century decision that held a father had complete control of his children until the age of twenty-one, the common law age of majority. Lord Denning ruled:

The common law can, and should, keep pace with the times. It should declare, . . . that the legal right of a parent to the custody of a child ends at the 18th birthday: and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice.¹¹⁰

In England the rights of capable young persons enunciated by the House of Lords in *Gillick v. West Norfolk and Wisbech Area Health Authority*¹¹¹ later became clouded by several decisions of the Court of Appeal that conflicted with *Gillick*.¹¹² In Canada, however, cases decided after *Gillick* would generally clarify the scope of the “mature minor” concept *vis-à-vis* parental authority, the inherent jurisdiction of superior courts in this respect, and the authority of the state under child protection legislation.

In 1986, the Alberta Court of Appeal, in *C.(J.S.) v. Wren*,¹¹³ adopted Lord Scarman’s reasons in *Gillick*¹¹⁴ and concluded that parental authority to consent to treatment ceases when a young person becomes capable of deciding her or his own medical treatment.

In 1994, the New Brunswick Court of Appeal, in *Walker*,¹¹⁵ ruled that the *parens patriae* jurisdiction of the superior courts ends when a young person is capable of giving or refusing consent to the young person’s medical treatment.¹¹⁶

In 1999, the British Columbia Court of Appeal, in *Van Mol*, adopted *Walker* and held a mature minor possesses “all rights” to give or withhold consent to medical treatment and, as a matter of law, is “entitled to be treated in the same way that any person of full age and capacity should [be] treated.”¹¹⁷

¹⁰⁹ (1883), 24 Ch.D. 317 (C.A.).

¹¹⁰ *Hewer*, *supra* note 103 at 369.

¹¹¹ *Supra* note 59.

¹¹² See consideration of these cases in discussion of comparative law, *infra* in Part 6(a).

¹¹³ [1987] 2 W.W.R. 669 (Alta C.A.).

¹¹⁴ *Supra* note 59 at 423.

¹¹⁵ *Supra* note 35.

¹¹⁶ *Ibid.* at 333-36.

¹¹⁷ *Van Mol*, *supra* note 44 at 676.

In 2007, the Manitoba Court of Appeal confirmed in *C.(A.)*, as a general common law proposition, that “mature minors, similar to adults, have the capacity to decide their own medical care.”¹¹⁸

ii) Rationale

The principles underlying the “mature minor” rule “are of long-standing duration”¹¹⁹ and are thoroughly supported by medical research on the mental capacity of children. An exhaustive review of children’s capacity by Ontario’s Weisstub Enquiry concluded: “The research is fairly consistent that if reasoning ability alone is the guide, children over the age of fourteen years are likely to be as capable as average adults.”¹²⁰

This conclusion finds support in clinical studies. For example, “classic”¹²¹ studies by Lois A. Weithorn, Thomas Grisso and Linda Veirling, “found that on a scale of capacity ranging from the mere ability to manifest a choice to the ability to appreciate the nature of treatment, fourteen-year-olds were capable of the highest standard of mental reasoning.”¹²²

Similarly, Lois A. Weithorn, in a “well-designed”¹²³ study on children’s competency to consent, compared children aged nine and fourteen to adults between the ages of eighteen and twenty-one. In general, “the performance of the 14 year olds was strikingly similar to that of the adults according to all standards of competency; factual understanding; inferential understanding (i.e., appreciation); reasoning process; reasonable outcome; and evidence of choice.”¹²⁴

The consensus among “all [expert medical] authors”¹²⁵ who have researched the capacity of children to consent to medical treatment is that

¹¹⁸ *C.(A.)*, *supra* note 33 at 54.

¹¹⁹ *Van Mol*, *supra* note 44 at 665.

¹²⁰ David N. Weisstub, *Enquiry on Mental Competency: Final Report* (Toronto: Queen’s Printer, 1990) at 145 [Weisstub Enquiry]. At 146 the *Enquiry* reported that a “number of authors recognize that an adult-like level of cognitive ability may be reached by the child by the age of eleven or twelve.”

¹²¹ Jennifer L. Evans, “Are Children Competent to Make Decisions About Their Own Deaths?” (1995) 13 *Behavioral Sciences & the Law* 27 at 32.

¹²² Weisstub Enquiry, *supra* note 120 at 144.

¹²³ Evans, *supra* note 121 at 32.

¹²⁴ Lois A. Weithorn, “Children’s Capacities for Participation in Treatment Decision-Making” in Diane H. Schetky and Elissa P. Benedek, eds., *Emerging Issues in Child Psychiatry and the Law* (New York: Brunner/Mazel, 1985) at 30.

¹²⁵ Lois A. Weithorn, “Involving Children in Decisions Affecting Their Own Welfare” in Gary B. Melton, Gerald P. Koocher and Michael J. Saks, eds., *Children’s Competence to Consent* (New York: Plenum Press, 1983) at 245.

“children aged 14 and older possess the requisite cognitive and intellectual capacities to render them comparable to adults, as a group, relative to competency. And, most of these authors recognize that many children attain this highest level of cognitive functioning by age 12.”¹²⁶

Of particular importance, the cognitive ability of many minors to provide consent is not limited to making less-serious medical treatment decisions. Some authors suggest that by the age of fourteen or fifteen “*most* adolescents can understand the ‘meaning of death’”¹²⁷ and, therefore, have the capacity to make their own potential life or death treatment decisions.

Dr. Christine Harrison, Director of Bioethics at the Hospital for Sick Children in Toronto, Ontario, suggests children be divided into three groups with respect to decision-making ability: infants and young children, who have no significant decision-making capacity; primary school children who may participate in medical decisions but lack full decision-making capacity; and adolescents, who generally have the decision-making capacity of an adult.¹²⁸

The scientific consensus on developmental capacity is consistent with McLachlin C.J.C.’s observation in *Starson* that “young children generally lack capacity to make medical decisions because of their age.”¹²⁹ The corollary is that some older children will have capacity to make complex medical treatment decisions, which is also the official position of the Canadian Paediatric Society on behalf of its 2,000 members.¹³⁰

Verifying scientific consensus on developmental capacity is the reported experience, albeit anecdotal, of medical practitioners such as Dr. A. R. Cooper, Chief of Pediatrics at the Dr. Charles A. Janeway Child Health Centre in St. John’s, who has observed:¹³¹

¹²⁶ *Ibid.*

¹²⁷ *Ibid.* at 249 [emphasis added].

¹²⁸ Christine Harrison, *et al.*, “Bioethics for Clinicians: 9. Involving Children in Medical Decisions” (1997) 156 *Can. Med. Assoc. J.* 825 at 827.

¹²⁹ *Starson*, *supra* note 15 at para. 7.

¹³⁰ Canadian Paediatric Society (CPS), Bioethics Committee, Position Statement, B2004-01, “Treatment Decisions Regarding Infants, Children and Adolescents” (2004) 9 *Paediatric Child Health* 99 [CPS, Position Statement]; see also Doig and Burgess, *supra* note 101 at 1585-87; Lawrence Schlam and Joseph P. Wood, “Informed Consent to the Medical Treatment of Minors: Law and Practice” (2000) 10 *Health Matrix* 141 at 142, 156; Rhonda Gay Hartman, “Adolescent Autonomy: Clarifying an Ageless Conundrum” (2000) 51 *Hastings L.J.* 1265 at 1286, 1305, 1319-20.

¹³¹ Affidavit of Austin Richard Cooper, August 2002, para. 12, filed in *H. (B.) (Next*

Health care professionals accept the mature minor concept and most of us are very comfortable with it. We respect our patients of any age and want to do what is best for them. However, if a patient is a mature minor and she or he refuses treatment for legitimate reasons, even though such a decision is against our medical advice and will, in our view, cause potential harm to the mature minor, we will still respect the minor's decision. This thinking is more than a hospital rule or a legal issue. The mature minor principle recognizes the intrinsic value of human life and the rights of individuals to choose their own fate.

5. *Charter Protection of Treatment Decision Rights of Capable Young Persons*

In *R. v. Morgentaler*, Wilson J. stated: “[T]he rights guaranteed in the *Charter* erect around each individual, metaphorically speaking, an invisible fence over which the state will not be allowed to trespass. The role of the courts is to map out, piece by piece, the parameters of the fence.”¹³² Regarding medical treatment of capable adults, the “fence” is largely well-defined. The Supreme Court has not yet decided, however, whether sections 7 and 15(1) of the *Charter* protect from state interference the treatment decisions of a person judicially found or assumed to be capable, who is under twenty-one, the common law age of majority.

Picard and Robertson express their considered opinion that legislation interfering with the treatment decisions of capable young persons would likely be struck down as unconstitutional:

If encroachment on the fundamental right to refuse treatment is unconstitutional in the case of adults, it is difficult to see why it would be different for “mature minors,” who by definition have the same capacity as adults to understand the nature and consequences of their decision to refuse treatment.¹³³

“[A]ge is an inadequate proxy for the maturity of a minor’s medical treatment decision,” concludes Lucinda Ferguson in her 2004 paper for the Law Commission of Canada. “There are,” she contends,

three aspects to the schism between age-based rules and the reality of minor’s development: first, there is no general level of psychological development at which we can categorize minors of the same age; second, the skills necessary

Friend of) v. Alberta (Director of Child Welfare). S.C.C. File No. 29174. The author of this article was counsel for H.(B), whose litigation is exhaustively considered and analyzed in Lori G. Beaman, *Defining Harm: Religious Freedom and the Limits of the Law* (Vancouver: UBC Press, 2008).

¹³² *R. v. Morgentaler*, [1988] 1 S.C.R. 30 at 164 [*Morgentaler*].

¹³³ Picard and Robertson, *supra* note 58 at 86.

for mature decision-making develop at different rates for each minor; third, because there is no single definition of a mature decision, individual minors may make mature health care decisions as a result of combinations of skills.¹³⁴

In the 2007 decision in *C.(A.)*,¹³⁵ however, the Manitoba Court of Appeal concluded it was constitutionally justifiable for the state to overrule the treatment decisions of capable young persons by prescribing sixteen as the minimum age for making binding medical treating decisions. Because the Supreme Court of Canada has granted leave to appeal, with argument pending, in *C.(A.)* the author will sparingly address the Manitoba Court's reasoning.

In *C.(A.)*, the Court of Appeal accepted that "mature minors, similar to adults, have the capacity to decide their own medical care."¹³⁶ The Court of Appeal also accepted that prescribing a minimum age for medical consent, below which the state can overrule a young person's treatment decisions, infringes the liberty and security of the person interest under section 7 of the *Charter*.¹³⁷

The Court of Appeal nonetheless cited three reasons to justify the infringement: (1) the state's interest in the "protection of children and sanctity of life;" (2) the "increased vulnerability and varying maturity of minors;" and (3) the "difficulty [of] determining capacity" in urgent situations.¹³⁸

First, while the state undoubtedly has an interest in the protection of "children" and the "sanctity of life," a foundational principle of Canadian society has long been that the personal autonomy and dignity of a capable person must prevail.¹³⁹ Reference the competing values of "autonomy" and "societal protection," McLachlin C.J.C. stated in *Starson*:

Ordinarily at law, the value of autonomy prevails over the value of effective medical treatment. No matter how ill a person, no matter how likely deterioration or death, it is for that person and that person alone to decide whether to accept a proposed medical

¹³⁴ Lucinda Ferguson *The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions* (Ottawa: Law Commission of Canada, 2004) at 79.

¹³⁵ *C.(A.)*, *supra* note 33.

¹³⁶ *Ibid.* at 54.

¹³⁷ On the facts of *C.(A.)*, *supra* note 33, the Court also concluded that legislation authorizing the imposition of unwanted blood transfusions infringed the religious conscience of the appellant, one of Jehovah's Witnesses, under the *Charter*, s. 2(a).

¹³⁸ *Ibid.* at 47, 67, 70.

¹³⁹ *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 595-96 (*per Sopinka J.*).

treatment. However, where the individual is incompetent, or lacks the capacity, to make the decision, the law may override his or her wishes and order hospitalization.¹⁴⁰

As McLachlin C.J.C.'s statements illustrate, the state interest in the protection of children and the sanctity of life is simply another way of expressing the state's *parens patriae* jurisdiction. That jurisdiction, discussed earlier, terminates when a person achieves consenting capacity. In *Fleming*, Robins J.A. held for the Ontario Court of Appeal that *parens patriae* jurisdiction "cannot be exercised by the state to overrule a treatment decision made by a competent patient, who, by definition, is able to direct the course of her or his medical care, regardless of the fact that the decision may be considered, by objective standards, medically unsound or contrary to the patient's best interests."¹⁴¹

In *C.(A.)* the Court of Appeal cited the varying maturity and vulnerability of "children" as a second reason to justify prescription of a minimum set age for medical consent. That observation, however, warrants an argument in favor of individualized determination of capacity.

The Manitoba Law Reform Commission gave credence to this argument when it recommended against an arbitrary age for medical consent:

[I]f the age chosen were not low enough, this would inevitably bar some mature minors with the necessary capacity from directing their future medical treatment. If the age chosen were too low, some minors who did not have the necessary capacity to direct their current medical treatment would nonetheless be allowed to direct their future medical treatment.¹⁴²

The Commission favored a legislative approach that would permit capable persons of any age to make a binding health care directive.

Kenny, Downie, and Harrison note that although "developmental milestones give us a general sense of capacities, there is no bright-line of a particular age that will indicate ability to participate in independent decision making."¹⁴³ Summarizing governing medical ethics and policy, they conclude that a capable young person "must be told

¹⁴⁰ *Starson*, *supra* note 15 at para. 7.

¹⁴¹ *Fleming*, *supra* note 71 at 91.

¹⁴² MLRC, *Self-Determination*, *supra* note 31 at 13-14.

¹⁴³ Nuala Kenny, Jocelyn Downie and Christine Harrison, "Respectful Involvement of Children in Medical Decision Making" in Peter Singer, ed., *The Cambridge Textbook of Bioethics* (Cambridge: Cambridge University Press, 2007) at 124.

everything that a competent adult would be told and has the moral authority to make the decision.”¹⁴⁴

Professor Ronda Hartman, after an exhaustive analysis of the developmental capacity of adolescents, concludes:

Since the research of Dr. Piaget and his progeny, a compilation of published studies on adolescent decisional capacity has accumulated, comprising examinations of adolescent decisional capacity in various contexts. These studies, some of which directly confirm Dr. Piaget’s findings, suggest that adolescents, aged 14 and older, possess the cognitive capability to reason, understand, appreciate, and articulate decisions comparable to young adults.

...

[Weithorn and Campbell] take the position that their results do not support the denial of adolescent self-determination in health care situations. This research confirms earlier preliminary findings that there is “little evidence that minors age 15 and above as a group are any less competent to provide consent than are adults.” The fact that scientific and social science research suggests no perceptible difference between the capacity of adolescents and young adults in medical treatment decision-making indicates that the law should refrain from capriciously constructing a dichotomy of presumptive differences in decisional autonomy.¹⁴⁵

Schlam and Wood similarly conclude:

Today, however, as a result of the “mature minor” doctrine, doctors may now treat children, even in the absence of parental consent or a court order, because it has become reasonable to assume that mature children are capable of providing informed consent pertaining to their own medical treatment.

...

Indeed, recent cognitive development studies have recognized that children over age fourteen can make mature and intelligent decisions about health care. The American Academy of Pediatrics Committee on Bioethics has not only supported the finding that children “achieve decisional capacity at (a) much earlier (age) than is recognized legally,” but based upon what we now understand to be the adolescent’s level of maturity and cognitive abilities, it recommends that adolescents should be more involved than at present in health care decision-making.¹⁴⁶

As a result, the Canadian Paediatrics Society directs that once adolescents achieve “sufficient decision-making capacity, they should become the principal decision maker for themselves.”¹⁴⁷

¹⁴⁴ *Ibid.* at 122.

¹⁴⁵ Hartman, *supra* note 130 at 1286, 1305, 1319-20.

¹⁴⁶ Schlam and Wood, *supra* note 130 at 142, 156.

¹⁴⁷ CPS, Position Statement, *supra* note 130 at 99.

The third point raised by the Manitoba Court of Appeal in *C.(A.)* to justify a minimum age for medical consent is the potential difficulty in determining capacity in urgent situations. The author has been unable to locate any case in which a court stated that difficulty was encountered in determining capacity in allegedly urgent circumstances.

The Manitoba Law Reform Commission, after interviewing health care professionals, observed:

We found that the mature minor rule is a well-known, well-accepted and workable principle which seems to raise few difficulties on a day-to-day basis. There was quite strong opposition to the use of a fixed age limit; the development of children was seen to be too variable to permit a fixed age to be a practical or workable concept. The interviews revealed no reason for concern in respect of the operation of the mature minor rule. Based on these interviews, the Commission has concluded that, generally, health care providers appear to approach the task in a highly responsible, caring and compassionate manner; good communication is a priority and significant amounts of information and advice are provided to mature minors.¹⁴⁸

The same is true of Ontario, Prince Edward Island, Newfoundland and Labrador, and Yukon where 41 percent (889,260) of Canada's 2,169,385 adolescents aged thirteen to seventeen reside.¹⁴⁹ In these provinces, provincial health care legislation recognizes the right of capable young persons of any age to decide their own medical care. These provinces have not reported any difficulty in the day-to-day application of their legislation.

¹⁴⁸ MLRC, *Minors' Consent*, *supra* note 30 at 33, 38. See also the April 15, 2003, expert opinion affidavit of Dr. Austin Richard Cooper filed in the Supreme Court of Canada in *U.(C.)*, *supra* note 53 at paras. 7-8, 10, SCC File No. 29432; Dr. Cooper states at para. 7 in particular:

The concept of the mature minor has been welcomed and endorsed by the medical profession. We treat our mature patients as consenting partners in their care regardless of their age. We have understood the mature minor concept as enabling us to do so. The maturity of the patient, as we understand the concept and as we experience in practise, is more important than age. All physicians would agree that there are some 15-year-olds who are more mature than some 25-year-olds. We as a profession have moved away from age restrictions that were applied without thought by previous generations of physicians and now agree to treat mature minors as adults. I am personally aware this happens every hour, every day, in every province and territory of Canada. The concept of a mature minor underlies all treatment of adolescents who are defined as children under Newfoundland law. We have evolved considerably in applying this concept and the public has obviously agreed.

¹⁴⁹ Statistics Canada, *supra* note 16.

The author submits that the correct constitutional balance under the *Charter* is that enacted by the legislatures of Ontario, Prince Edward Island, Newfoundland and Labrador, and Yukon. Under sections 7 and 15(1) of the *Charter*, a capable person of any age should be permitted to decide on her or his medical care, to the exclusion of the state and all others. A legislatively-set minimum age for medical consent is arbitrary, lacking any credible clinical or other scientific basis, and is consequently offensive to section 15(1) and contrary to the substantive principles of fundamental justice required under section 7.¹⁵⁰ Such legislation inevitably precludes from making treatment decisions some young persons who, because of advanced maturity and long-term experience with their particular illness, in fact have the necessary capacity to do so. The standard test for *Charter* compliance of such legislation should be whether the individual is capable of giving or refusing consent, or choosing alternatives, to the recommended medical treatment, not whether the individual has reached a legislated arbitrary fixed age. That standard is consonant with entrenched *Charter* principles of liberty, security of the person, and equality, while recognizing that state and judicial *parens patriae* jurisdictions exist for the benefit of persons incapable of deciding for themselves.¹⁵¹

Further, a brief analysis of comparative law in England and the United States, which follows, is instructive in illustrating that a legislatively-fixed age for medical consent by capable young persons should be rejected in favor of a standard based exclusively on individual capacity to decide.

6. Comparative Law

a) England

1) “Gillick Competence”

The foremost common law authority in England on whether and how a minor’s decision impacts the minor’s medical treatment is *Gillick*.¹⁵² In England, “no statute governs the rights of people under 16 to give consent to medical treatment.”¹⁵³ In *Gillick*, the House of Lords considered a challenge by the mother of five daughters under sixteen to

¹⁵⁰ *Chaoulli v. Quebec (A.G.)*, 2005 SCC 35, [2005] 1 S.C.R. 791 at paras. 130-133.

¹⁵¹ *Fleming*, *supra* note 71 at 91.

¹⁵² *Supra* note 59; see also *R. v. Secretary of State for Health and the Family Planning Association, ex parte Axon*, [2006] 1 FCR 175 (Q.B.D.).

¹⁵³ British Medical Association (BMA), *Consent, Rights and Choices in Health Care for Children and Young People*, (London: BMJ Publishing Group, 2001) at 34.

a Department of Health policy making contraceptive services available to persons under sixteen without parental consent. In dismissing the challenge, Lord Scarman for the majority held that parental consent for treatment of a person under the age of sixteen is not required where the young person is capable of making the treatment decision. He enunciated the common law test for “*Gillick* competence” in these terms:

[A]s a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminated if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues except in “exceptional circumstances” such as requires the minor’s emergency treatment.¹⁵⁴

The effect, in Canada, of *Gillick* appears not to have been diluted by *obiter* comments of Lord Donaldson, M.R. in two subsequent decisions from England’s Court of Appeal.¹⁵⁵

2) “Multiple Keyholders”

The fifteen-year-old in *Re R. (A Minor)*¹⁵⁶ exhibited acute psychotic behaviour. She was admitted under the *Mental Health Act 1983* to a psychiatric unit where staff proposed medicating her. While momentarily lucid, R indicated she would not consent to medication the unit proposed. A judicial order to authorize the drug treatment of R was sought. Because R was found incompetent, the issue whether her consent was a treatment pre-requisite was moot.

On appeal, Lord Donaldson agreed R was not “*Gillick* competent” due to her illness’s fluctuating nature.¹⁵⁷ Although unnecessary for his decision, he added, in *obiter*: (1) before a minor becomes “*Gillick* competent” only the minor’s parents—in the role of “keyholders”—are able to “unlock the door” to afford consent for their minor child’s medical treatment;¹⁵⁸ (2) on the minor becoming “*Gillick* competent,”

¹⁵⁴ *Gillick*, *supra* note 59 at 423-424.

¹⁵⁵ BMA, *supra* note 153 at 35 expressed the opinion that the subsequent decisions by Lord Donaldson, discussed below, were an attempt to drive “a coach and horses” through the House of Lords decision in *Gillick*.

¹⁵⁶ *Re R. (A Minor)(Wardship: Consent to Treatment)*, [1991] 3 W.L.R. 592 (C.A.) [*Re R.*].

¹⁵⁷ *Ibid.* at 601.

¹⁵⁸ *Ibid.* at 599.

the minor's parents cease to exclusively hold the right to consent; instead, the right to consent is jointly held by the minor and her parents; and (3) a physician, to be authorized to treat the minor, need only obtain consent from one of the "keyholders," either the minor or one of the minor's parents.¹⁵⁹ In contrast, *Gillick* concluded that from the time a minor becomes capable of choosing medical treatment, the minor's parents have *no* role in consent to medical treatment.¹⁶⁰

3) "Legal 'Flak Jacket'"

The sixteen-year-old in *Re W. (A Minor)*,¹⁶¹ was diagnosed with anorexia nervosa. She refused physician-recommended treatment. She took the position that she enjoyed the same right as an adult to refuse treatment and to have that decision respected. She relied on section 8 of the *Family Law Reform Act 1969*,¹⁶² which reads in part:

The consent of a minor . . . [from 16 up to 18 years] to any surgical, medical or dental treatment . . . shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.¹⁶³

The Court found a result of W's illness was destruction of "the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective."¹⁶⁴ Thus, the Court held W was incapable to give treatment consent.

As in *Re R.*, consideration of whether the consent of W was a precondition of her being treated was redundant because of her incapacity to give consent. Nonetheless Lord Donaldson stated in *obiter* (substituting a doctor's "legal 'flak jacket'" for a family's multiple "keyholder analogy")¹⁶⁵ that a physician need only obtain consent from one of the persons entitled to provide it: (1) a "*Gillick* competent" minor (under the age of sixteen); (2) a minor aged sixteen or older (based on section 8 of the *Family Law Reform Act 1969*); or (3) another source, having parental

¹⁵⁹ Rosy Thornton, "Multiple Keyholders—Wardship and Consent to Medical Treatment" [1992] Cambridge L.J. 34 at 36.

¹⁶⁰ *Gillick*, *supra* note 59 at 423-424.

¹⁶¹ *Re W. (A Minor)*(*Medical Treatment: Court's Jurisdiction*), [1992] 3 W.L.R. 758 (C.A.) [*Re W. Jurisdiction*].

¹⁶² *Family Law Reform Act 1969* (U.K.), 1969, c. 46.

¹⁶³ *Ibid.* at s. 8(1).

¹⁶⁴ *Re W. Jurisdiction*, *supra* note 161 at 769.

¹⁶⁵ *Ibid.* at 767.

responsibility for the minor, such as a parent or a superior court exercising *parens patriae* jurisdiction. Having received, from one of these sources, consent to treatment of a minor, the treating doctor is equipped with a “legal ‘flak jacket’” that protects the doctor from civil battery claims or criminal assault complaints on behalf of or by the minor.

Lord Donaldson added *obiter* that although a minor's consent to treatment cannot, by virtue of section 8 of the *Family Law Reform Act 1969*, be overridden by a parent, a court may in exercise of what he terms its “limitless” *parens patriae* powers, which “certainly extend beyond the powers of a natural parent,”¹⁶⁶ override the minor's treatment choice if, in the court's opinion, the choice is not in the minor's best interest. In that event, the capable young person's treatment choice is reduced, in the court's exercise of *parens patriae* jurisdiction, to an “important consideration.”¹⁶⁷ How this ambiguous factor is to be employed and weighted is not articulated.

Lord Donaldson's proposed judicial modification of the common law, albeit *obiter*, has not been followed in Canada. For example, Huddart J.A. of the British Columbia Court of Appeal, in her majority concurring decision in *Van Mol*, did not regard the proposed modification “to be necessary or desirable.”¹⁶⁸

Whether medical treatment choices of a capable minor in England are protected by the *European Convention on Human Rights*, adopted in England October 2, 1998, remains to be determined.¹⁶⁹

b) *United States*

Federal appellate jurisprudence under the Fourteenth Amendment to the United States Constitution, legislation, and appellate decisions in some American states, have recognized the “mature minor” concept in addressing capacity to make capable medical treatment decisions.

1) *Federal Protection of Treatment Decisions of Capable Young Persons*

The Fourteenth Amendment provides:

No State shall . . . abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due

¹⁶⁶ *Ibid.* at 769.

¹⁶⁷ *Ibid.* at 772.

¹⁶⁸ *Van Mol*, *supra* note 44 at 686.

¹⁶⁹ BMA, *supra* note 153 at 32, 34.

process of law; nor deny to any person within its jurisdiction the equal protection of the laws.¹⁷⁰

The “due process of law” requirement of the Fourteenth Amendment “forbids the government to infringe . . . ‘fundamental’ liberty interests *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.”¹⁷¹

In *Cruzan v. Director, Missouri Department of Health*, Chief Justice Rehnquist of the United States Supreme Court ruled that “a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment” under the Fourteenth Amendment.¹⁷² This fundamental liberty interest was reaffirmed in *Washington v. Glucksberg*, in which Chief Justice Rehnquist ruled that “the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment.”¹⁷³

Although each of these decisions involved adults, “neither the Fourteenth Amendment nor the Bill of Rights is for adults alone.”¹⁷⁴ The Supreme Court, in *Planned Parenthood of Central Missouri v. Danforth*, wrote that constitutional rights “do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”¹⁷⁵

¹⁷⁰ U.S. Const. amend. XIV.

¹⁷¹ *Reno v. Flores*, 507 U.S. 292 at 302 (1993) [emphasis in original].

¹⁷² 497 U.S. 261 at 278 (1990) [*Cruzan*].

¹⁷³ 521 U.S. 702 at 720 (1997) [*Washington*]. In a concurring opinion, Justice Stevens went further than the majority, stating at 743: “I insist that the source of Nancy Cruzan’s right [in reference to the Court’s 1990 decision in *Cruzan*, *supra* note 172] to refuse treatment was not just a common-law rule. Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces, not merely a person’s right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death.”

In *Washington*, *ibid.* and its companion case, *Vacco v. Quill*, 521 U.S. 793 (1997), the Supreme Court unanimously upheld state statutes banning assisted suicide. In the *Vacco* decision, Justice Rehnquist stated at 800: “*Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide” [emphasis added]. This careful distinguishing between refusing lifesaving medical treatment and suicide was supported with extensive footnoted medical and legal references.

¹⁷⁴ *Re Gault*, 387 U.S. 1 at 13 (1967).

¹⁷⁵ 428 U.S. 52 at 74 (1976) [*Danforth*]; see also *Bellotti v. Baird*, 443 U.S. 622 at 633 (1979) [*Bellotti*], which states: “A child, merely on account of his minority, is not beyond the protection of the Constitution.”

For example, in *Hodgson v. Minnesota*, the Supreme Court decided “the constitutional protection against unjustified state intrusion into the process of deciding whether or not to bear a child extends to pregnant minors as well as adult women.”¹⁷⁶ And, in *Planned Parenthood v. Casey*, the Court, reaffirming earlier decisions,¹⁷⁷ decided that if parents or guardians of an “unemancipated young woman under 18” do not consent for the young woman to abort, the “court may authorize the performance of an abortion upon a determination that the young woman is mature and capable of giving informed consent and has, in fact, given her informed consent.”¹⁷⁸

The state may, the Supreme Court decided in *Bellotti v. Baird*, “adjust its legal system” to account for the general inability of minors to make critical decisions in an informed, mature manner, including resort “to objective, though inevitably arbitrary, criteria such as age limits.” However, “the State . . . may not arbitrarily deprive [minors] of their freedom of action altogether.” Minors who are “mature enough and well enough informed”¹⁷⁹ to make their own decisions must be allowed to do so as a matter of federal constitutional law.

2) *State Protection of Treatment Decisions of Capable Young Persons*

States may afford further protection of, and define, the fundamental rights of their citizens through their state constitutions and statute provisions.¹⁸⁰ While this would ordinarily enhance the protection of capable treatment decision-making, enunciated by the Supreme Court of the United States, state trial courts in particular have struggled with

¹⁷⁶ 497 U.S. 417 at 435 (1990); see also *Carey v. Population Services International*, 431 U.S. 678 at 693 (1977) where the court held: “State restrictions inhibiting privacy rights of minors are valid only if they serve ‘any significant state interest . . . that is not present in the case of an adult.’”

¹⁷⁷ See e.g. *Danforth*, *supra* note 176 at 74-75.

¹⁷⁸ *Planned Parenthood v. Casey*, 505 U.S. 833 at 899 (1992). Of interest, if a minor possesses sufficient maturity to make an informed and independent decision, the minor is entitled to make the decisions free from unwarranted state interference; see *Bellotti*, *supra* note 176 at 650. In *Akron (City of) v. Akron Center for Reproductive Health*, 462 U.S. 416 at 441 (1983), the Supreme Court suggested that a child protection statute which did not provide for case-by-case evaluations of minors’ decision-making capacity would be constitutionally defective for failing to balance the liberty interests of capable minors with the sovereign’s legitimate *parens patriae* interest in the welfare of minors generally.

¹⁷⁹ *Bellotti*, *supra* note 176 at 635, 637, n. 15; 643, 643, n. 23.

¹⁸⁰ Some states have adopted capable minor provisions. See, for example, Arkansas Code Ann. Sec. 82-363(9) (Mitchie 1993); Idaho Code Sec. 39-4302 (1993); Nevada Rev. Stat. Ann., Sec. 129.030(2) (Mitchie 1992); and New Hampshire Rev. Stat. Ann. Sec. 318-B: 12-2 (1993).

the balancing of this fundamental right against a multiplicity of perceived state interests. In two notorious cases in 1994, the capable treatment decisions of young persons were not only judicially rejected; the full force of state authority was used to impose treatment against their wishes.

Benito (Benny) Agrelo, fifteen years old, received, and his body rejected, two liver transplants. He no longer wished to take anti-rejection medication (eight drugs, three times a day) and declined consent to a recommended third transplant. Florida, under its child protection legislation, had five police officers forcibly remove him from his home and take him to hospital to have treatment imposed. Ultimately, a circuit court judge, after hearing evidence from Mr. Agrelo, ruled he could not be forced to accept medical treatment he did not want.¹⁸¹

California also used its child protection legislation to force fifteen-year-old Lee Lor to undergo ten days of chemotherapy for her ovarian cancer. To hospitalize her, seventeen police officers, six social workers, and paramedics broke through the door of the family home and transported her, strapped to a gurney. After her discharge from hospital, she fled the family home on learning that a child protection hearing had been scheduled to determine if she should be placed in foster care, to facilitate administration of a treatment order requiring chemotherapy. She returned three months later, after the court vacated the order.¹⁸²

In contrast, decisions of many state appellate courts have held capable young persons possess the right to *choose* medical treatment and to *refuse* an unwanted medical procedure.¹⁸³

*Re E.G. (A Minor)*¹⁸⁴ involved a seventeen-year-old minor diagnosed with acute nonlymphatic leukemia. E.G., one of Jehovah's Witnesses, consented to all recommended treatment except blood transfusions. The physician for E.G. testified she "was competent to

¹⁸¹ Joan-Margaret Kun, "Rejecting the Adage 'Children Should be Seen and Not Heard'—The Mature Minor Doctrine" (1996) 16 Pace L. Rev. 423 at 423. Ms. Kun interviewed Broward County Circuit Court Judge Arthur Birken on September 6, 1994. No formal opinion was released in this case because the matter involved a parental neglect action. See also Isabel Traugott and Ann Alpers, "In Their Own Hands: Adolescents' Refusal of Medical Treatment" (1997) 151 Archives of Pediatrics & Adolescent Medicine 922 at 923-24.

¹⁸² Traugott and Alpers, *ibid.*

¹⁸³ For a comprehensive survey of state jurisprudence relating to mature minors see Schlam and Wood, *supra* note 130; Hartman, *supra* note 130.

¹⁸⁴ 549 N.E.2d 322 (Ill. 1989) [*Re E.G.*].

understand the consequences of accepting or rejecting treatment, and he was impressed with her maturity and the sincerity of her beliefs.”¹⁸⁵ Nevertheless, the trial court vested the state with temporary custody of E.G. and authority to consent to blood transfusions for her. E.G. prevailed in her appeal to the Illinois Court of Appeal.

The Supreme Court of Illinois, in upholding the Court of Appeal, ruled that “[a]lthough the age of majority in Illinois is 18, that age is not an impenetrable barrier that magically precludes a minor from possessing and exercising certain rights normally associated with adulthood.”¹⁸⁶ The Court could “see no reason why [the] right of dominion over one’s own person should not extend to mature minors.”¹⁸⁷

In *Re Rena*¹⁸⁸ a seventeen-year-old minor lacerated her spleen while snowboarding. Her doctors thought a blood transfusion might become necessary.¹⁸⁹ As one of Jehovah’s Witnesses, she would not consent to transfusions. The Massachusetts trial court authorized transfusions.¹⁹⁰

On appeal, the Court of Appeal reversed the trial judge, finding that although the trial court considered the “wishes and . . . religious convictions” of the young woman, he “made no determination as to [her] maturity to make an informed choice.”¹⁹¹ The appellate court regarded the 1999 Illinois Supreme Court decision in *Re E.G.*¹⁹² as persuasive authority and held that “in assessing Rena’s preferences and religious convictions,” the trial court “should have heard Rena’s own testimony on these issues where she apparently had the testimonial capacity to answer questions.”¹⁹³

¹⁸⁵ *Ibid.* at 323.

¹⁸⁶ *Ibid.* at 325.

¹⁸⁷ *Ibid.* at 326.

¹⁸⁸ 705 N.E.2d 1155 (Mass. App. Ct. 1999).

¹⁸⁹ *Ibid.* at 1156.

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.* at 1157.

¹⁹² *Re E.G.*, *supra* note 185.

¹⁹³ *Ibid.* See also *Decker v. Carroll Academy*, [1999] WL 332705 (Tenn. Ct. App.) (WL) where the Tennessee Court of Appeal held that under the Rule of Sevens (similar to the “mature minor” rule) parental consent to medical treatment is not required where the minor is 14 years of age or older.

7. Conclusion

“Childhood,” writes Edna St. Vincent Millay, lyrical poet and playwright, “is the kingdom where nobody dies.”¹⁹⁴ Sadly, the reality is otherwise. Children get sick. They suffer from the same misfortunes as adults—accidents, disease, and terminal illness. Some of them die.

Infants and young children undoubtedly need and deserve the protection of their personal guardians. Where a personal guardian is unable or unwilling to act to protect the child, then the state and courts, in exercise of their inherent *parens patriae* jurisdiction, step into the shoes of the parent or other personal guardian and make necessary parental decisions, including treatment decisions, on the child’s behalf.

There comes a time in a young person’s maturation, however, when parents and other guardians, the state, and the courts must relent. When a young person, irrespective of age, achieves decision-making capacity, the parental, state and judicial role changes from that of decision-maker to the limited, although important, function of supportive advisor and friend. Paternalism must then yield to the reality that mature minors have the same capacity as adults to choose medical treatment: a right recognized at common law, authorized by medical consent and advance medical directive legislation, and protected by the *Charter*; a right which eclipses *parens patriae*—and any other—authority of both legislature and court. Canadian hospitals and health care practitioners daily assess the capacity of mature minors, as they do with all other patients (sometimes in exigent circumstances) to give treatment instructions for all types of medical procedures, and rely on those instructions. This practice quite properly respects, and is congruent with, the mature minor’s cognitive and psychological ability; fosters an essential relationship of trust and respect between the patient and caregiver, and occasions enhanced therapeutic value inherent in patient-approved medical treatment.

Who decides the medical treatment of a capable young person? Common law and *Charter* guarantees, together with the realities of a young person’s cognitive and psychological development, and of medical practice, confirm that it should be the capable young person.

¹⁹⁴ Edna St. Vincent Millay, quoted in Robert Kastenbaum, “Childhood: The Kingdom Where Creatures Die” (1974) 3 J. Clinical Child Psychol. 11 at 11.