Manitoba

Law Reform Commission

Commission de réforme du droit

MINORS' CONSENT TO HEALTH CARE

December 1995

Report #91

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CHAPTER 1

INTRODUCTION

The Chair of the Consent Committee of the Health Sciences Centre in Winnipeg asked the Manitoba Law Reform Commission to examine the issue of consent of minors to medical treatment. In particular, the Commission was asked about the advisability of legislation to clarify the law on this issue. This Report responds to that request.

A. BALANCING COMPETING INTERESTS

A number of competing interests and policies collide in the area of consent to medical treatment of minors. The primary tension is between a minor's right to autonomy, to make his or her own decisions about medical treatment, and the parental interest in the welfare of children and the preservation of their life and health. The key actors in this area bring different perspectives, concerns and desires. As children develop towards majority, they seek greater control over their lives and bodies. Demands for freedom of choice, self-determination and autonomy are deserving of some degree of protection prior to full adulthood (18 years). Parents are primarily interested in the welfare of their children and their health. However, most parents accept that responsibility, care, control and paternalism must gradually diminish as the maturity of a child develops. Health care providers seek the power to treat and further the health and interests of children in an environment of legal certainty and predictability. Finally, the public at large, society, has a fundamental interest in the health of its children.

The challenge to the legal system is to accommodate and balance these competing policies and interests and to achieve a framework to facilitate just and fair solutions to these conflicts.

B. STRUCTURE OF THE REPORT

We begin our Report in Chapter 2 by setting out the current law in Manitoba. In Chapter 3, we discuss the need for reform. Chapters 4 to 6 examine the law and proposals for reform in other jurisdictions. Finally, we make our proposals for reform in Chapter 7; our recommendations are restated in Chapter 8.

C. ACKNOWLEDGEMENTS

The Commission gratefully acknowledges Prof. Philip H. Osborne of the Faculty of Law, University of Manitoba, who was retained as our consultant and to prepare this Report. His assistance in guiding us through the difficult policy issues addressed in this Report was invaluable and we extend our most sincere thanks.

CHAPTER 2

THE CURRENT LAW IN MANITOBA

Three broad areas of the law intersect at the issue of consent of minors to medical treatment. Tort law deals with civil liability for damages to compensate for unauthorized medical treatment. Criminal law provides for the punishment of those who interfere with persons without their consent. Professional associations regulate the professional and ethical duties of physicians and other health care providers and they enforce those standards by means of disciplinary procedures and penalties. Unauthorized medical treatment may give rise to tort, criminal and/or disciplinary proceedings. This Report deals primarily with civil liability for damages and the exposure of health care providers to legal claims from minors or their parents in respect of unauthorized treatment. Criminal law plays a minor role in health care and, in any event, falls within the exclusive jurisdiction of Parliament. Professional associations do not regulate the capacity of patients to consent. Those associations look to the civil law for guidance on such questions.

While the primary focus of this Report is the common law of tort and its exposition of principles relating to the consent of minors to health care, we have not overlooked the contribution of the provincial Legislature. Some legislation deals directly with the consent issue. Some Acts deal indirectly with the issue by prescribing age requirements in respect of other activities and privileges. That legislation will be summarized after we describe the nature and scope of tort law as it relates to the validity of a minor's consent.

A. TORT LAW

For centuries, tort law has upheld the proposition that an intentional interference with the person of another which is either offensive or harmful is actionable as a battery. The high degree of protection which the law gives to our interest in personal security and integrity is indicated by the fact that damages are awarded for battery without proof of harm or loss. A battery may, however, be justified by proof of the person's consent to the interference. In those circumstances, no liability is imposed.

These principles are equally applicable to the field of health care. Medical examination or treatment may only take place with the full and voluntary consent of the patient. Unauthorized treatment amounts to a battery. There is one important exception to that cardinal principle. A physician is privileged to provide necessary and emergency treatment to preserve the life or health of a patient when a patient, or another person having authority to consent, is unable to provide the requisite consent.

The importance of the general rule recognizing the patient's power to accept or refuse medical treatment has recently been affirmed by Linden J. He wrote:

> While our Courts rightly resist advising the medical profession about how to conduct their practice, our law is clear that the consent of a patient must be obtained before any surgical procedure can be conducted. Without a consent, either written or oral, no

> surgery may be performed. This is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done and by whom it will be done.[1]

The law is, however, less definitive in respect of the medical treatment of minors. Where children do not have the capacity to consent, parental consent is essential. This is a form of substitute consent given by parents or guardians in the best interests of the child. The critical issue, however, is to determine when a child is empowered to make his or her own medical decisions independently of parental control.

For many purposes, the age of majority (18 years) is utilized to draw the line between childhood and adulthood. However, in respect of medical treatment, the common law has been less definitive and has recognized the validity of a minor's consent to medical treatment where the minor has displayed a sufficient number of the indicia of adulthood. Common sense and common practice dictate that parental consent should not be necessary in respect of all medical treatment of all minors. It would be unreasonable to suggest that quite a young child has no power to consent to minor first aid for abrasions, contusions and lacerations. It would be equally unreasonable to suggest that an employed and married 17 year old does not have the capacity to make his or her own decisions in respect of health care. Consequently, the law has sought to draw a distinction between minors who have the capacity to consent to health care and those who do not. Not surprisingly, judges have not been able to formulate a 'bright line' test to determine a minor's capacity which is certain and predictable in all cases. There are too many variables including the different physical, emotional and intellectual maturity of each child, the nature of the parent-minor relationship, the lifestyle of the minor and the nature of the medical condition for which treatment is sought.

The law has sought to accommodate these variables by developing tests of capacity which require an evaluation of each minor and his or her stage of development towards adulthood. The courts have developed two concepts to assist in identifying those minors who have the capacity to consent to medical treatment without parental knowledge, guidance or sanction. The earliest idea to appear in the cases is that of "emancipation" from parental control and guidance (the emancipated minor rule). The more recent and popular notion is that of maturity (the mature minor rule).

The emancipated minor test is satisfied by evidence that the minor has adopted a lifestyle which indicates that he or she has assumed responsibility for his or her own life. The minor may have left home, married, entered the workforce or, in other ways, indicated that he or she is no longer subject to parental control and is making his or her own decisions affecting his or her life. The emancipated minor test is illustrated by the case of *Booth* v. *Toronto General Hospital.*[2] In that case, a 19 year old, who was two years younger than the age of majority at that time, consented to surgery on his throat. The validity of that consent was at issue. Falconbridge C.J. stated:

> The only question of law involved was whether the boy's parents should have been consulted, but that was effectively answered, and it has been shewn that he is capable of doing a man's work. Indeed, he is at present doing hard work for 10 hours a day.[3]

[1] *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.).

[2] *Booth* v. *Toronto General Hospital* (1910), 17 O.W.R. 118 (K.B.).

[3] *Id.*, at 120.

Elsewhere, his Lordship commented that the patient was capable of "taking care of himself"[4] and was an emancipated minor capable of providing valid consent to treatment.

It is not surprising that the concept of emancipation was utilized early in this century. The courts had to respond to a situation where the age of majority was uniformly high (21 years) and the age of entry into the workforce and marriage was on average lower than it is today.

The emergence of the mature minor rule is likely a reflection of changing socio-economic circumstances which tend to delay entry into the workforce, marriage and the completion of education to later years. The mature minor rule focuses less on the minor's lifestyle and more on the minor's physical, emotional and intellectual development. Under this rule, any minor who has a full appreciation of the nature and consequences of medical treatment may consent to medical treatment. Consequently, a mature minor, living at home and attending school, may consent to medical treatment. This rule was first recognized in Canada in *Johnston* v. *Wellesley Hospital*.[5] In that case, a 20 year old minor consented to a course of treatment for acne by a dermatologist. Addy J. held that parental consent was not essential. He said:

> . . . it 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, would, at law, be incapable of consenting thereto.[6]

Consequently, the minor satisfied the mature minor rule and parental consent was not necessary. Initially, there was some doubt about the scope of the *Johnston* decision. First, the patient was 20 and, in every respect other than age, was an adult person. The decision did not speak to the more difficult situation involving much younger minors. Secondly, the treatment provided was of a relatively minor cosmetic nature. *Johnston* was, therefore, in some ways an 'easy' case.

Some assistance on both these points was provided by the House of Lords decision in *Gillick* v. *West Norfolk and Wisbech Area Health Authority*.[7] In England, legislation has empowered those aged 16 years and over to make their own medical decisions. However, the mature minor rule continues to apply to those under the age of 16. *Gillick* dealt with the capacity of a young woman under the age of 16 to consent to receiving contraceptive advice and treatment. The Court held that, in exceptional circumstances, a mature minor may have such a power. Lord Fraser felt that the physician could proceed without parental consent if a number of conditions were satisfied:

> . . . (1) that the girl (although under 16 years of age) will understand his advice; (2) that he [the physician] cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.[8]

Lord Scarman stated:

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[4]*Booth* v. *Toronto General Hospital*, *supra* n. 2, at 120.

[5]*Johnston* v. *Wellesley Hospital* (1970), 17 D.L.R. (3d) 139 (Ont. H.C.).

[6]*Id.*, at 144.

[7]*Gillick* v. *West Norfolk and Wisbech Area Health Authority*, [1985] 3 All E.R. 402 (H.L.).

[8]*Id.*, at 413.

> . . . [T]he parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[9]

However, two areas of potential disagreement flowed from the decision in *Gillick*. First, the judges did not appear to agree on the meaning of maturity. Lord Fraser seems to emphasize intellectual maturity and the understanding of the nature of the treatment. Lord Scarman seems to take a more holistic approach to maturity. He stated:

> When applying these conclusions to contraceptive advice and treatment it has to be borne in mind that there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed on the basis that she has at law capacity to consent to contraceptive treatment.[10]

The second area of difficulty is Lord Fraser's condition that the medical treatment must be in "the best interests of the child". This has been referred to as "the welfare principle" and has been subjected to serious criticism. It has been argued that independent and autonomous decision-making normally carries with it the right to fully determine what is in one's own best interests and to make decisions which others may perceive as mistaken. The welfare principle suggests that a mature minor only has the power to make the "right" decision: the decision that is, or is perceived by the health care provider to be, in his or her best interests.

Some clarification of these issues is found in the leading Canadian case of *C. (J.S.)* v. *Wren*.[11] In that case, the patient was a 16 year old woman. While she was living at home with her parents, she became pregnant by her boyfriend. Several weeks later, she moved out of her parents' home and did not return. In due course, she went to the defendant-physician for an abortion. The physician was willing to perform the abortion and approval was given by a therapeutic abortion committee as then required under the *Criminal Code*. The parents sought a judicial order to prevent the abortion on the grounds that a minor could not be given an abortion without parental consent. At this time, the age of majority in Alberta was 18. The judge refused to make the order and his decision was upheld on appeal.

Kerans J.A. spoke for the Alberta Court of Appeal. He cited the House of Lords decision in *Gillick* v. *West Norfolk and Wisbech Area Health Authority*[12] with approval and noted that there was some support for the view that maturity encompassed more than an intellectual understanding of the proposed medical treatment. The Court noted that the parents and the minor had discussed the ethical dimensions of abortion. In the last analysis, however, the Court stressed that "she is a 'normal intelligent 16-year-old'"[13] and, at that age and level of understanding, could make her own decision.

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[9] *Gillick* v. *West Norfolk and Wisbech Area Health Authority*, *supra* n. 7, at 423.

[10] *Gillick* v. *West Norfolk and Wisbech Area Health Authority*, *supra* n. 7, at 424.

[11] *C. (J.S.)* v. *Wren*, [1987] 2 W.W.R. 669 (Alta. C.A.).

[12] *Gillick* v. *West Norfolk and Wisbech Area Health Authority*, *supra* n. 7.

[13] *C. (J.S.)* v. *Wren*, *supra* n. 11, at 672.

The welfare principle seems to play no part in the Court's decision. This may be because the minor had already secured, as then required, the permission of the therapeutic abortion committee. Nevertheless, cases such as this expose the difficulties with the welfare principle. It is not easy for a physician to assess objectively whether an abortion is in a minor's best interest. Furthermore, as noted earlier, the evaluation of the minor's best interests may seem incompatible with a finding of maturity sufficient to make an autonomous decision.

One other helpful case, though in a somewhat different context, is *Re A.Y.*[14] In this case, a 15 year old Jehovah's Witness boy suffered from terminal cancer. There was a less than 50% chance that aggressive chemotherapy might bring a remission or slow the progress of the disease. The patient, in agreement with the parents, consented to chemotherapy but refused the transfusion of blood products which is often needed after such treatment. The Director of Child Welfare applied, under child protection legislation, for a declaration that the patient, being under 16, was "a child in need of protection" and an order authorizing blood transfusions. The Newfoundland Supreme Court held that he was not "a child in need of protection" because the blood transfusions, in light of the evidence, could not be viewed as essential. Of greater relevance to our discussion, however, is the additional finding of Wells J. that the patient was a mature minor whose wishes in respect of the blood transfusions must be respected. His Lordship was influenced by *Re L.D.K.*[15] where a judge refused to find a 12 year old cancer patient who refused conventional treatment to be in need of protection. In that case, the child, whose parents supported her decision, was found to have "wisdom and maturity beyond her years". She had unshakeable religious views and the Court believed that she should be given an opportunity to fight the disease with dignity and peace and in accordance with the plan put forward by the patient and her parents. In *Re A.Y.*, Wells J. reached a similar conclusion. He stated:

> . . . I think that what has happened has made A. mature beyond any normal expectation of maturity in a 15-year-old. I think the boy that I spoke to this morning is very different from a normal 15-year-old, because of his tragic experience.
>
> I think he is mature enough to express a cogent view . . . and I am satisfied that he is a mature, young adult.[16]

His Lordship held that his wishes should be respected.

Both *Re A.Y.* and *Re L.D.K.* give support to the concept of maturity and that such a finding brings the right to make autonomous decisions.

Of course, it should be noted that, in both these cases, the parents supported the child's decision and the Court did not find the treatment decisions to be against the child's best interests. In these circumstances, the Court was unwilling to sanction state interference to force unwanted treatment when that treatment had a very low chance of success.

In conclusion, it is clear that the mature minor rule is firmly entrenched in Canadian common law. There are, however, some aspects of the rule that need further clarification. For example, maturity may involve more than an intellectual appreciation of the nature and risks of the medical treatment *per se*. The court may also consider ethical, emotional maturity, particularly in difficult and controversial areas such as contraceptive treatment, abortion and the treatment of sexually-transmitted disease. The welfare principle has also yet to be tested. It may be seen as incompatible with mature, autonomous and independent decision-making. However, hard cases will test the extent of the court's commitment to the autonomy of mature minors.

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[14] *Re A.Y.* (1993), 111 Nfld. & P.E.I.R. 91 (Nfld. S.C.).

[15] *Re L.D.K.* (1985), 48 R.F.L. (2d) 164 (Ont. Prov. Ct.).

[16] *Re A.Y.*, *supra* n. 14, at 96.

Some of those hard cases will centre on a mature minor's right to refuse beneficial and necessary treatment favoured by both parents and the medical establishment. It will arise when mature minors refuse life-saving treatment when the chances of success are good and the treatment is supported by parents and the medical professionals. It can also arise in cases of a mature minors' consent to non-therapeutic sterilization, although it is unlikely that a physician would be willing to perform such a procedure.

Hard cases such as these have recently led English courts to retreat to some extent from the views of the House of Lords in *Gillick*. In *Re W*,[17] for example, it was held that maturity does not extinguish all parental or judicial power to authorize medical treatment of mature minors and that parents or courts may provide a valid consent to beneficial treatment refused by a mature minor.

B. LEGISLATION

While legislation does not deal in any general way with the capacity of minors to consent to medical treatment in Manitoba, there are a number of legislative provisions which are directly relevant to particular kinds of medical treatment and indirectly relevant to the health care of young persons. We survey those which are most pertinent.

1. *The Human Tissue Act*

The Human Tissue Act[18] deals, among other things, with the live donation of body parts by both adults and minors. This legislation is important not only for the rules it prescribes in this area but also because it reflects legislative policy in respect of the difficult questions in respect of medical procedures which are not always in the best interests of the patient (donor). Donation of tissue has no therapeutic advantage to the donor and, in some cases, may be detrimental to that person as in the case of donation of non-regenerative tissue. The Act prescribes special rules for three separate categories of donors.

First, persons over the age of majority have the power to donate regenerative and non-regenerative tissue for therapeutic purposes and regenerative tissue for educational and research purposes. The consent of the donor is not, however, valid unless a physician who has no relationship with the recipient certifies in writing that the donor understands the nature and effect of the procedure.

Secondly, minors between 16 and 18 years of age, who would likely be categorized as mature minors at common law, may consent to the transplant of regenerative and non-regenerative tissue in certain circumstances. Donation is permitted with parental consent when the recipient is a member of the donor's immediate family and a physician not associated with the tissue recipient certifies in writing that the donor understands the nature and effect of the procedure. This may reflect a reluctance on the part of the Legislature to recognize that the mature minor has the same capacity as an adult in the area of non-therapeutic treatment.

Thirdly, minors under the age of 16 may consent to the transplant of tissue to another person if the following conditions are met:

- the donor consents;

[17] *Re W (a minor) (medical treatment)*, [1992] 4 All E.R. 627 (C.A.).

[18] *The Human Tissue Act*, C.C.S.M. c. H180.

- the tissue is regenerative tissue;
- the recipient would likely die without the transplant;
- the risk to the life and health of the donor is relatively insubstantial;
- the person giving consent is a member of the recipient's immediate family;
- the consent of the parent or guardian is given;
- the transplant is recommended by a physician who does not have any association with the proposed recipient;
- the transplant is approved by the Court of Queen's Bench.

Clearly, great caution is being exercised by the Legislature in respect of those under 16.

2. *The Mental Health Act*

The Mental Health Act[19] has some special provisions in respect of psychiatric treatment in a psychiatric facility. Section 24.1(1) states:

> Treatment decisions may be made on behalf of a patient who is a minor or who is not mentally competent by a person who is apparently mentally competent, is available and willing to make the decision and who is
>
> (a) the patient's guardian, if the patient is a minor; or
>
> (b) in the case of a patient who has no guardian,
>
> (i) the patient's proxy, or
> (ii) if there is no proxy, the patient's nearest relative.

The purpose of the provision is not totally clear. It might be noted that it applies to all minors, both mature and immature. The permissive language, however, does not make parental consent essential. It is therefore likely to be applied where a minor refuses to consent to appropriate psychiatric treatment. As such, it may be seen as a limitation of the mature minor rule insofar as psychiatric treatment in a psychiatric facility is concerned. Again, this is indicative of a legislative reluctance to entrust to the mature minor the full autonomous independence of an adult. This may be seen as giving some support to the welfare principle which limits a mature minor's power of consent to "beneficial" decisions.

3. *The Health Care Directives Act*

The Health Care Directives Act[20] recognizes and controls the power of persons to create legally effective living wills. Living wills are designed to permit patients to control their health care when they are not able to do so because they have ceased to have capacity to consent or are unable to communicate their wishes. They are often used in emergencies and in the later stages of progressive diseases when personal decision-making may not be possible. A directive may contain a health care decision relating to consent or refusal to certain kinds of treatments and/or

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[19] *The Mental Health Act*, C.C.S.M. c. M110.

[20] *The Health Care Directives Act*, C.C.S.M. c. H27.

it may appoint a proxy to make health care decisions when the patient loses the capacity to do so or the ability to communicate. To be operative, a health care directive must be written, signed and dated.

For the purposes of this Report, it is useful to identify the approach under the Act to the issue of capacity to make a living will. Capacity is defined in section 2 as an ability "to understand the information that is relevant to making a decision" and an ability "to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

Section 4, however, reduces the degree of uncertainty in respect of mature minors by introducing certain presumptions. In the absence of evidence to the contrary, a person who is 16 years old or more is presumed to have the capacity to make health care decisions and a person under the age of 16 is presumed not to have the capacity to make health care decisions. Clearly, the legislation anticipates that a mature minor under the age of 16 *may* make a health care decision if evidence is produced of that patient's capacity.

The Act is an important indication of legislative policy in respect of the independence and autonomy of mature minors. Minors with sufficient capacity may make health care directives refusing blood transfusions or, in the case of anorexia nervosa, refusing certain kinds of treatment such as forced feeding. The policy of the Legislature appears to be that a finding of capacity places the minor in the same position in respect of health care as an adult.

4. Part III of *The Child and Family Services Act*

The Child and Family Services Act[21] does not directly affect the age of consent but that part of the Act which deals with child protection does relate to children who do not receive proper medical treatment.

The central notion of the child welfare legislation is "child in need of protection". That finding triggers a series of procedures designed to secure the child's life, health and emotional well-being. The issue arises in health care most often in respect of parental refusal or neglect to provide health care for their child who, for the purposes of the Act, is defined as a person under the age of majority. The pertinent part of section 17 reads:

> . . . a child is in need of protection where the child . . . is in the care, custody, control or charge of a person . . . who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or well-being of the child or who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner; . . . .[22]

Cases from other jurisdictions with similar legislation give some guidance to the approach of the courts to the meaning of child in need of protection. Both *Re L.D.K.*[23] and *Re A.Y.*[24] have been mentioned earlier. These cases involved an application to apprehend minors who, with parental support, had refused life-saving treatment which had a low chance of success. In each case, the Courts found that the children were mature minors who had made a rational and intelligent decision in respect of their health care. The Courts refused to find the children in need of protection. It would appear that maturity is a significant factor in deciding whether an apprehension should take place under the Act.

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[21] *The Child and Family Services Act*, C.C.S.M. c. C80.

[22] *The Child and Family Services Act*, C.C.S.M. c. C80, s. 17(2)(b)(iii).

[23] *Re L.D.K.*, *supra* n. 15.

[24] *Re A.Y.*, *supra* n. 14.

Section 25 deals with the powers of the agency to consent to medical treatment of minors apprehended for whatever reasons.[25] Under section 25(1)(b), the agency may authorize a medical examination of a child where the consent of a parent or guardian would otherwise be required. This would seem to refer to immature minors since parental consent is necessary in those circumstances at common law. Under section 25(1)(c), the agency may authorize the medical or dental treatment of the child if the treatment is recommended by a physician or dentist, consent of a parent or guardian would otherwise be required (immature minor), and a parent or guardian is not available to consent to treatment. Section 25(2) declares that the agency has no power to provide consent to a medical examination or medical or dental treatments when the child is 16 or over without the minor's consent. These provisions do not directly deal with the mature minor who is under 16. The legislation appears to be premised on the assumption that parental consent or consent of a guardian is required whenever the child is under 16. Subsections 25(3) to (9) deal with the power of an agency to apply to the court for an order where there is a refusal of treatment by a child or by a parent or guardian. If the minor is 16 years or older, a court order may only be secured if the minor lacks the capacity to understand the information that is relevant to making a decision to consent or not to consent to medical examinations or medical or dental treatment and to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical examination or the medical or dental treatment. An order may also be sought to authorize medical or dental treatment where parents or guardians refuse to consent to treatment of a child under 16. Again, the Act does not recognize the concept of a mature minor under 16. It provides for an appropriate hearing to take place before any order shall be made and the court may order any medical examination or medical or dental treatment that it considers to be in the best interests of the child.

Section 25(10) provides an immunity for the agency, the hospital or other facility where the examination or treatment is provided and the person examining or treating the child from any liability arising by reason only that a parent or guardian of the child or the child did not consent to the examination or treatment. The immunity is not expressly conditional on the good faith of the participants.

At this point, it is opportune to mention an alternative procedure available when appropriate medical care is not provided to a minor. Application can be made to the Court of Queen's Bench to sanction medical treatment of a minor. A superior court has an inherent *parens patriae* jurisdiction to intervene in the best interests of children.

The jurisdiction is not always ousted because there is legislation in the field. La Forest J. described the breadth and importance of this jurisdiction in *Re Eve*. He stated:

> . . . even where there is legislation in the area, the courts will continue to use the *parens patriae* jurisdiction to deal with uncontemplated situations where it appears necessary to do so for the protection of those who fall within its ambit. . . .
>
> . . . [T]he situations in which the courts can act where it is necessary to do so for the protection of mental incompetents and children have never been, and indeed cannot, be defined.
>
> . . . .
>
> . . . The courts will not readily assume that it has been removed by legislation where a necessity arises to protect a person who cannot protect himself.[26]

[25] *The Child and Family Services Act*, C.C.S.M. c. C80, as am. by S.M. 1995, c. 23.

[26] *Re Eve* (1986), 31 D.L.R. (4th) 1 at 17 and 28 (S.C.C.).

5. The *Criminal Code*

The *Criminal Code* is not relevant to the minor's capacity to consent to medical treatment. However, it is worthy of attention to the extent that it reflects Parliament's assessment of the maturity of young people. Section 150.1 indicates that the consent of a person who is 14 years or older is a defence to sexual assault and other sexual offences. Consent is not a defence if the complainant is under 14 except where he or she is at least 12 and accused person is at least 12 yet under 16 years of age, is less than two years older than the complainant and is neither in a position of trust or authority towards the complainant nor is a person with whom the complainant is in a relationship of dependency.[27]

6. Other Statutes

There are a number of statutes in Manitoba which regulate the capacity of young people to participate in "adult" activities. In respect of some, the age of majority (18) is the threshold criterion. The right to vote,[28] the right to be on licensed premises[29] and the right to marry without parental approval[30] are among the rights secured at the age of 18. Other statutes set lower age limits in respect to other privileges and activities. Both the ages of 16 and 12 are operative in certain situations. *The Highway Traffic Act*[31] and *The Public Schools Act*[32] set 16 as the age at which a person may be licensed to drive an automobile and leave school, respectively. *The Employment Standards Act*[33] sets the general age for employment at 16. Fewer rights are secured at 12 but legislation indicates that, in respect of some matters, the views and decisions of those who are 12 and over must be respected. *The Change of Name Act*[34] prevents the name of a child 12 years or over being changed without the child's written consent. While *The Child and Family Services Act*[35] defines child as a person under the age of majority, it does include a number of provisions giving rights to those aged 12 and over. Section 2(2) states that a child of 12 or more is entitled to be advised of any proceedings relating to him or her and to be advised of the possible implications of such proceedings. He or she is also entitled to an opportunity to be heard in the proceedings. Section 2(3) states that the view and preferences of children under the age of 12 may be taken into account by the judge or master where the child is able to understand the nature of the proceedings and where such input would not be harmful to the child. Elsewhere in the Act, other provisions require that a child who is 12 or over be given information and/or be consulted.[36] It might also be noted that 12 is the age at which a child will not be deemed "in need of protection" if he or she is left "unattended and without reasonable provision being made

[27]*Criminal Code*, R.S.C. 1985, c. C-46, s. 150.1(2).

[28]*The Elections Act*, C.C.S.M. c. E30, s. 32(1).

[29]*The Liquor Control Act*, C.C.S.M. c. L160, s. 93(1).

[30]*The Marriage Act*, C.C.S.M. c. M50, s. 18(1).

[31]*The Highway Traffic Act*, C.C.S.M. c. H60, s. 24(9)(a).

[32]*The Public Schools Act*, C.C.S.M. c. P250, ss. 258(1) and (2).

[33]*The Employment Standards Act*, C.C.S.M. c. E110, ss. 1 and 9(1).

[34]*The Change of Name Act*, C.C.S.M. c. C50, s. 4(3).

[35]*The Child and Family Services Act*, C.C.S.M. c. C80, s. 1.

[36]See, e.g., *The Child and Family Services Act*, C.C.S.M. c. C80, ss. 19.1(3)(d), 20(2) and 33(2).

for the supervision and safety of the child".[37] Finally, it is worthy of note that no child who is 12 or more may be adopted without his or her written consent.[38]

This discussion of legislation is by no means complete and exhaustive. It is perhaps sufficient to reflect the equivocal nature of governmental policy in respect of age requirements of young people and the difficulty of determining a single age in respect of all matters.

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[37]*The Child and Family Services Act*, C.C.S.M. c. C80, s. 17(2)(g).

[38]*The Child and Family Services Act*, C.C.S.M. c. C80, s. 58(1)(b).

CHAPTER 3

ASSESSMENT OF THE CURRENT LAW

The mature minor rule has been the subject of some criticism. Some of the issues may have become apparent in the course of our description of the principle. Here, we identify some of those concerns.

A. UNCERTAINTY

The mature minor rule is firmly entrenched in Canadian common law but, like all common law doctrines, there continues to be some uncertainty about its precise scope, interpretation and application. For example, some doubt remains about the precise meaning of maturity. The stronger view is that it involves an intellectual understanding of the information relating to the minor's medical condition and proposed treatment and an appreciation of the risks and benefits of that treatment and the consequences of inaction. The other view is that emotional and moral factors are also to be taken into account. The extent of a mature minor's power to refuse beneficial treatment also remains to be fully worked through; can a mature minor give consent or refusal to treatment when others, such as the minor's parents, physicians and courts, perceive that decision as being contrary to the minor's best interests?

B. DIFFICULTY IN THE APPLICATION OF THE MATURE MINOR TEST

From time to time, physicians may encounter some difficulty in determining the maturity of an individual patient. That is not likely to occur where a physician has, for many years, been the child's pediatrician. However, if a minor presents himself or herself at an emergency department of a hospital or a walk-in medical clinic, it may be very difficult to determine the patient's maturity.

C. DEFENSIVE MEDICINE

The current law may encourage health care providers to act conservatively in respect of minors. The law is technically unforgiving of a mistake in the determination of maturity. If, in the crystal clarity of hindsight, a court later determines that the minor was immature, liability may be imposed. This may lead physicians to refuse to treat mature minors unless they can be assured of both the maturity of the patient and their ability to prove it.

D. IMPEDIMENTS TO TREATMENT

The current law may provide impediments to children receiving essential medical treatment. Few cases have considered the issue of maturity in respect of children under 16. Today, however, much younger minors encounter medical problems for which they may seek treatment without parental involvement. This is of particular concern when the medical problem

relates to sexually-transmitted diseases, pregnancy, alcohol or drug abuse, contraception and abortion. Some of these medical matters have a socio-economic dimension which impacts on the public interest. These situations indicate the importance of unimpeded access to medical treatment. The courts have, however, had little opportunity to indicate their approach to the application of maturity principles to those in the 12 to 16 age category. Physicians may seek the comfort and safety of parental consent, thereby deterring some young people from seeking the treatment they need.

E. CHILDREN'S RIGHTS

Some hold the view that the law does not sufficiently recognize and validate the increasingly early maturity of children. Child rights' advocates argue for greater recognition of the interest of children in having greater input into medical decisions affecting them. Many argue for a legal readjustment of the relationship between parents and children in favour of increased rights to children and a corresponding diminution in parental control.

It is useful to keep these concerns in mind as we turn to the experience of other jurisdictions and the work of other law reform agencies in the area of consent to treatment.

CHAPTER 4

LEGISLATIVE REFORM IN OTHER PROVINCES

A number of provinces have passed legislation to clarify or reform the law relating to the consent of minors to health care. This legislation varies in both its scope and substance. The approach in each province will be considered separately.

A. NEW BRUNSWICK

New Brunswick is the only province to pass the *Uniform Medical Consent of Minors Act* adopted and recommended at the 1975 Annual Meeting of the Uniform Law Conference of Canada. The work of the Uniform Law Conference of Canada in this area is discussed later. Here we consider the New Brunswick *Medical Consent of Minors Act*.[1] The Act begins with a broad definition of medical treatment. It does not, however, include the controversial area of contraceptive treatment and advice.

Section 2 states that the law respecting consent to medical treatment of persons who have attained the age of majority shall apply in all respects to persons who are aged 16 or over. It should be noted that this provision is free of any limitation or welfare principle.

Consent to treatment by minors under the age of 16 is effective when the attending physician is of the opinion that the minor is capable of understanding the nature and consequences of the medical treatment and that the treatment is in the best interests of the minor and his or her continuing health and well-being so long as that opinion is supported in writing by another physician. The welfare principle which appears to be inapplicable in respect of those 16 and older is clearly pertinent in respect of those under 16. The Act does appear to protect the physician from *bona fide* error. So long as his or her opinion is determined in good faith and supported by another physician, there will be no liability if, in fact, the minor did not understand or the treatment was not in his or her best interests.

The remainder of the Act is of less immediate relevance. Section 3 sets out an emergency exception in respect of minors under the age of 16 where parental consent cannot be secured and an immature minor's life or health is in imminent risk. This section appears to do little more than replicate the common law emergency principle.

Section 4 deals with the refusal of a parent or guardian to give a necessary consent to the treatment of a minor. An application can be made to the Court of Queen's Bench to dispense with parental consent where withholding the treatment would endanger the life or seriously impair the health of the minor. In Manitoba, this issue is dealt with by *The Child and Family Services Act* or the *parens patriae* jurisdiction of the Court of Queen's Bench.

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[1] *Medical Consent of Minors Act*, R.S.N.B. 1973, c. M-6.1.

A recent case in New Brunswick dealt with this legislation. In *Region 2 Hospital Corp.* v. *Walker*,[2] the patient was a 15 year old Jehovah's Witness who suffered from leukemia. He refused to consent to necessary blood transfusions in the course of his treatment. An application was made by his physicians and the hospital in which he was a patient for authorization that blood products be withheld in accordance with the patient's wishes. The New Brunswick Court of Appeal applied the Act. Two doctors attested as to the patient's maturity and that the decision was in his best interests. The Court found the patient to be a mature minor who could determine his own treatment. It may be noted that the parents supported the minor's decision and the chances of successful treatment were not good.

B. BRITISH COLUMBIA

As early as 1973, the British Columbia Legislature passed legislation which significantly changed the law in respect of consent to health care by minors. In that year, section 16 of the *Infants Act*[3] was passed. That legislation, however, proved unsatisfactory and on January 1, 1993, section 16 was replaced by a significantly different approach. We will look at each of these initiatives.

1. Section 16 of the *Infants Act* (1973)

This legislation was influenced to some degree by the English *Family Law Reform Act 1969*[4] which allowed persons between 16 and the age of majority to consent to medical treatment. It will be seen, however, that the British Columbia legislation had less to do with providing a right of self-determination to persons between 16 and 18 than about establishing a framework for providing treatment to them when parents were unavailable to give consent.

The Act provided that a person between 16 and 18 had the power to consent to medical treatment if two conditions were met. First, reasonable efforts must have been made to secure parental consent. Secondly, the attending physician or dentist must have secured a second, written opinion that the proposed treatment was in the best interests of the continued health and well-being of the patient.

This legislation exhibited little commitment to the autonomy of those aged 16 and over. Both the attending physician and another physician had to be convinced that the treatment was in the patient's best interests and, furthermore, the attending physician had a right to inform the parents that treatment had been provided. Confidentiality of the minor was not protected.

By the late 1990s, section 16 of the *Infants Act* had become anomalous. Minors aged 16 and over were subject to the legislative requirements of the *Infants Act*. Those under 16 were subject to the mature minor rule. The common law test was, however, more liberal than the legislation. A mature minor aged 15 had a greater power of self-determination than a minor aged 17. This led to the 1992 amendment.

2. Section 16 of the *Infants Act* (1992)

The British Columbia Legislature could have repealed the 1973 provision and allowed the common law to govern. The Legislature decided, however, to introduce a new provision. Its

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[2] *Region 2 Hospital Corp.* v. *Walker* (1994), 150 N.B.R. (2d) 362 (C.A.).

[3] *An Act to Amend the Infants Act*, S.B.C. 1973, c. 43; *Infants Act*, R.S.B.C. 1979, c. 196.

[4] *Family Law Reform Act 1969* (U.K.), 1969, c. 46.

intent appears to be to codify the common law mature minor rule. In so doing, however, the common law rule has to some degree been both extended and clarified. The new provision is set out below.

> 16. (1) In this section
>
> "health care provider" includes a person licensed, certified or registered in British Columbia to provide health care;
>
> "health care" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care.
>
> (2) Subject to subsection (3), an infant may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the infant's person, and where an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian.
>
> (3) No request for or consent, agreement or acquiescence to health care by an infant shall constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care
>
> (a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and
>
> (b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.[5]

There are a number of important aspects to this section.

1. The central concept of maturity is codified in section 16(3)(a). Maturity is satisfied by proof of an understanding of the nature and consequences of the health care and its reasonably foreseeable benefits and risks. Maturity is not even presumptively linked to any age. Moreover, maturity seems largely a question of intelligence and comprehension. There is certainly no emphasis on wider questions of emotional, ethical and religious maturity.

2. Section 16(3)(b) contains a welfare principle. The health care provider must make reasonable efforts to determine and conclude that the health care is in the minor's best interests.

3. The language of the section appears to protect a health care provider from honest errors in respect of the assessment of the capacity to understand the nature of the treatment and the best interests of the minor. The wording is that the health care provider is *satisfied* of the infant's understanding, not that the infant did, in fact, have the capacity to understand. In respect of best interests, the requirement is to use reasonable efforts to determine that the care is in the minor's best interests, not that it *is* in the infant's best interests. The language could be more felicitous but the intent seems clear.

4. The section empowers mature minors not only to consent to treatment but also to refuse treatment. Consequently, a mature minor may refuse beneficial treatment. This has led to some criticism. Broom[6] reports that the head of pediatrics at Children's Hospital in Vancouver expressed concern that children ill with cancer may be deemed competent to stop painful therapy.

5. There is no requirement that the parents be informed of the health care that has been provided to their child. The confidentiality of the mature minor is fully protected.

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[5] *Miscellaneous Statutes Amendment Act, 1992*, S.B.C. 1992, c. 77, s. 2.

[6] J.L. Broom, "The Recent Amendment to the *Infants Act*: A Look at Some of the Legal Issues" (1993), 51 The Advocate 391.

6. The wording of the section is such as to make some extensions to the common law mature minor rule. It has often been assumed that the mature minor rule applies to medical treatment given by physicians. The legislation contains a very broad definition of "health care provider" which widens the scope of the rule. It includes nurses, psychologists, chiropractors and others. The legislation also contains a wide definition of health care which would appear to encompass all forms of treatment. "Anything done for a health related purpose" is particularly broad. The wording of section 16(2) may also involve some extension of the common law doctrine. Consent is normally perceived as essential to protect a health care provider from an action in battery. The power given to a mature minor is to consent to health care *whether or not* it would be a trespass in the absence of consent. Finally, Broom[7] has pointed out the consequences of the use of the word "acquiescence" in section 16(3). The section includes the words "consent, agreement or acquiescence". He has pointed out that consent has a connotation of positive words or action indicating agreement to treatment. Acquiescence connotes a more passive stance indicated by a failure to object. He expresses some concern at a minor's acquiescence in a relationship of power imbalance being sufficient to authorize treatment.

In *Ney* v. *Canada (A.G.)*,[8] section 16 of the *Infants Act* was unsuccessfully challenged on constitutional grounds. In the course of his judgment, Huddart J. commented on the scope and meaning of the Act. The applicants were members of the Citizens Research Institute, a society concerned with preserving the family as a fundamental unit of the community. His Lordship responded to a number of objections to the Act. The first and primary objection to the legislation was the wording of section 16(3) which purported to protect health care providers from liability where they had acted in good faith and had taken reasonable steps to determine that the health care was in the best interests of the patient. It was argued that such a protection was undesirable and that health care providers should be at risk of liability for erroneous assessments of maturity. Huddard J. explained that the section was not merely protective of health care providers. It permitted parental concerns to be addressed. He noted that, while a determination of the patient's best interests was left to the health care provider, the reasonable efforts necessary to determine that question would require a discussion of relevant moral and family factors and, in some circumstances, "consultation with concerned parents".[9] This latter suggestion appears to diminish the autonomy of the mature minor in a significant way and impinges on the patient's interest in confidentiality. Consequently, it appears to undermine the intent of the Act. The second objection was that the Act permitted a mature minor to dictate the medical treatment he or she desired. His Lordship pointed out that this was not so. He noted:

> A health care provider is not required to treat a child just because the child is capable of giving consent and has consented to be treated. . . .[10]

Finally, the plaintiffs objected to the legislation on the ground that it does not provide a method of overriding a mature minor's refusal to consent to treatment. His Lordship noted that this was an unresolved issue at common law and that the legislation did not clearly deal with it. On one view, the mature minor has a full right to consent or refuse treatment. On the other view, mature minors and parents have concurrent powers of consent which parents may exercise where the mature minor refuses treatment. His Lordship did not comment on this issue other than to recognize that a decision of parents or child may be overridden under the provisions of the *Family and Child Service Act*[11] or by the court acting under its *parens patriae* jurisdiction.

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[7] *Id.*, at 398.

[8] *Ney* v. *Canada (A.G.)* (1993), 79 B.C.L.R. (2d) 47 (S.C.).

[9] *Id.*, at 54.

[10] *Ney* v. *Canada (A.G.)*, *supra* n. 8, at 56.

[11] *Family and Child Service Act*, R.S.B.C. 1979, c. 119.1 as en. by S.B.C. 1980, c. 11.

Overall, His Lordship concluded that section 16 of the *Infants Act* does no more than codify the common law and that it is constitutional.

C. ONTARIO

1. Introduction

Ontario has recently introduced comprehensive new laws governing the care of persons who lack the capacity to make their own personal decisions. The legislative package included the *Substitute Decisions Act, 1992*,[12] the *Advocacy Act, 1992*,[13] the *Consent to Treatment Act, 1992*[14] and the *Consent and Capacity Statute Law Amendment Act, 1992*.[15]

The *Consent to Treatment Act, 1992*[16] codifies the law relating to consent to medical treatment and establishes rules and procedures for administering health care to incapable persons. The Act does not deal with minors as a discrete entity but the principles and procedures established also cover those whose incapacity flows from youth rather than age or illness.

A few words about the general workings of the Act may be useful before concentrating on its impact on minors. The Act covers treatment provided by all licensed health care practitioners and extends its scope to anything done "for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose".[17] The central concept of the Act is capacity. Those who have capacity as defined in the Act have a full power to consent to or refuse treatment. Capacity is present when the health practitioner determines that the patient has an understanding of information covering the treatment and an ability to appreciate the reasonably foreseeable consequences of the health care decision. A consent given by such a person will be valid so long as it is voluntary, informed, related to the treatment and is uninfluenced by fraud or misrepresentation.

The primary concern of the Act is, however, for those who are found to lack capacity to make personal health care decisions. In this situation, the Act defines certain rights and duties pertaining to their health care. First, the patient may challenge the health care practitioner's decision that he or she lacks capacity. The Act sets up administrative procedures to ensure that the patient receives information and assistance from a "rights adviser" to assist in any application to the Consent and Capacity Review Board. The Board may overrule the health care practitioner and find that the patient has capacity to consent to the treatment. Final appeal is to the courts. The Act also details a hierarchy of substitute decision makers who may act on behalf of incapable persons and codifies the principles under which they must act. We now turn to the manner in which this Act applies to minors.

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[12] *Substitute Decisions Act, 1992*, S.O. 1992, c. 30.

[13] *Advocacy Act, 1992*, S.O. 1992, c. 26.

[14] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

[15] *Consent and Capacity Statute Law Amendment Act, 1992*, S.O. 1992, c. 32.

[16] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

[17] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31, s. 1(1) [definition of "treatment"].

2. *Consent to Treatment Act, 1992* and Minors

Under the Act, minors who have capacity may consent to or refuse all health treatment as defined by the Act. That evaluation will be made by the individual health practitioner applying prescribed standards and procedures to the patient. The health practitioner is protected from liability in respect of assessment errors. No liability attaches if the health practitioner has acted on reasonable grounds and in good faith. Although an individual assessment of each minor is required, some guidance may be given by section 2(2) of the *Substitute Decisions Act, 1992*[18] which establishes a presumption that those who are 16 years or older are capable of giving or refusing consent in respect of their own personal care. To this extent, the *Consent to Treatment Act, 1992* closely reflects the common law.

The innovative aspect of this Act relates to a finding of incapacity of a minor who does not wish to secure parental consent. Two situations must be considered. If the minor is 14 or over, very specific rules and procedures are in place to facilitate a challenge of that decision before the Consent and Capacity Review Board. Normally, a rights adviser will be involved to inform, advise and, if desired, assist in making an application to the Board to reverse the finding of incapacity. Unless there is an emergency, treatment must be delayed until the administrative procedures and any consequent appeal have taken place.[19] Secondly, slightly different consequences pertain in the unlikely event of a minor under 14 wishing to challenge a health practitioner's finding of incapacity. The Act clearly allows a person of any age to make an application to the Board. However, there is nothing in the Act requiring that information, advice and counselling be provided by a rights adviser or others to minors under 14. The matter must commence and proceed on the initiative of the minor and, therefore, is unlikely to take place.

We speculate that minors are unlikely to utilize this administrative framework to challenge decisions of incapacity. After all, the initiation and processing of a challenge before the Board, without parental knowledge, would seem to demand a degree of maturity that would be sufficient to satisfy the legislative definition of capacity.

As mentioned earlier, the Act also provides for substitute decision makers where a minor does not have capacity. The primary substitute decision maker is the person with parental authority. There is also a welfare principle requiring the substitute decision maker to act in the best interests of the minor.

There has been some criticism of the complexity of this legislation and it is being substantially revised by the Ontario government.[20]

3. *Hospital Management Regulation*

Section 26(1) of the *Hospital Management Regulation*[21] requires the written consent of a parent, lawful custodian or next-of-kin for non-emergency surgery on a person who is unmarried

[18] *Substitute Decisions Act, 1992*, S.O. 1992, c. 30.

[19] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31, s. 9.

[20] Bill 19, *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1996*, 1st Sess., 36th Leg. Ont., 1995.

If passed, the legislation will repeal the *Advocacy Act*, eliminate the Advocacy Commission and replace the *Consent to Treatment Act* with a new *Health Care Consent Act*.

It would also amend the *Substitute Decisions Act*, streamlining procedures for appointing substitute decision-makers, clarifying the role of the Public Guardian and Trustee, and making it easier for family members to take over decision-making for incapable relatives.: "Ontario to amend SDA", *The Lawyers Weekly*, December 1, 1995, 24.

[21] *Hospital Management Regulation*, R.R.O. 1990, Reg. 965 made pursuant to the *Public Hospitals Act*, R.S.O. 1990, c. P.40.

and under the age of 16. Section 26(2) makes the same demands where an attending physician, dentist, midwife or administrator requires a written consent before a diagnostic test or medical treatment is performed on a patient. This regulation was of dubious legal effect prior to the enactment of the *Consent to Treatment Act, 1992*[22] and is anomalous at best following the coming into force of that Act.

D. QUÉBEC

In Québec, the principles relating to the consent of minors are contained in articles 14 to 18 of the *Civil Code*. Articles 14 and 16 deal with consent to care which is "required by the state of health of a minor" and articles 17 and 18 deal with consent to treatment which is not required by the state of health of the minor. This dichotomy of required and non-required treatment would seem to contain some difficulties in interpretation. Nevertheless, it is essential to the legislative framework in respect of minors' consent.

1. Consent to Care Required by the State of Health of the Minor

In respect of treatment required by the state of health of the minor, parental consent or consent of a tutor (guardian) is required unless the minor is 14 years or older. If aged 14 or older, a minor alone may give consent to such care. Moreover, if the minor is confined in a health or social services establishment for over 12 hours, the parent or tutor must be told of that fact. It appears that confidentiality is eroded only to the extent necessary to allay parental fears for the safety of the minor.

Article 16 deals with refusal to consent to required treatment. A court may authorize such treatment where a parent or tutor has withheld consent in respect of a minor under 14. The second paragraph of article 16 deals with the difficult situation of a minor 14 or older refusing required treatment. In such a circumstance, the minor's refusal may be overridden by court authorization or, where there is an emergency and the minor's life is in danger or his or her integrity is threatened, the consent of a parent or tutor is sufficient. Clearly, Québec does not regard minors between 14 and 18 as having the complete autonomy of an adult. Refusal of life-saving treatment and other required treatment may, depending on the circumstances, be negated by judicial or parental fiat. Article 23 states that, in deciding whether to authorize required treatment, the court must consider the views of experts, parents and the patient and may also consider the views of any person who shares a special interest in the patient.

2. Consent to Care Not Required by the State of Health of the Minor

Persons under the age of 14 are incapable of consenting to non-required care. Parental consent is necessary and sufficient in all cases except when the care entails a serious risk to health or if it might cause grave and permanent effects. In the latter cases, court authorization is necessary.

Persons aged 14 or older may give consent alone to non-required care unless the care entails a serious risk to the health of the minor and may cause him grave and permanent effects, in which case parental consent is also required. Again, the autonomy of the minor 14 and older is limited in the interests of his or her overall welfare. Article 24 requires that consent to non-required care must be in writing.

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[22] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

The *Civil Code* also deals with human tissue transplant and research in respect of minors, topics which are beyond the scope of this Report.

E. OTHER PROVINCES

A number of Canadian jurisdictions have regulations made under provincial legislation which purport to deal with the age of consent in respect of certain medical procedures in hospitals. These regulations have a limited scope and considerable doubt has been thrown on their validity. It is unlikely that regulations made under legislation dealing with hospital management can affect the age of consent to medical treatment.[23] Nevertheless, for the sake of completeness, we describe the nature and scope of these regulations.

1. Saskatchewan

Section 55(1) of *The Hospital Standards Regulations, 1980*[24] regulates consent to non-emergency surgery in Saskatchewan hospitals. Parental consent is necessary in respect of all persons under the age of 18 unless the minor is married. The parental consent must be written and signed. The provision clearly seeks to curtail the mature minor's rights at common law.

2. Prince Edward Island

Section 48 of the *Hospital Management Regulations*[25] of Prince Edward Island also requires a written parental consent to non-emergency surgery from all unmarried persons under the age of 18. The regulation is a mirror image of that in Saskatchewan and again limits the rights of mature minors.

3. Northwest Territories

Section 87 of the *Hospital Standards Regulations*[26] in the Northwest Territories is a special provision dealing with the discharge of a patient contrary to medical advice. It declares that an in-patient may only be discharged under the authority of a written order signed by the patient, attending medical practitioner, the hospital, the Board or, if the patient is under 19, by a parent or guardian, provided that the parent or guardian also signs an accompanying statement releasing the hospital from responsibility for the discharge.

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[23] M.L. McCall and G.B. Robertson, "Legal Rights of Children to Health Care in the Common Law Jurisdictions of Canada" in B.M. Knoppers, ed., *Canadian Child Health Law* 151 at 164-165.

[24] *The Hospital Standards Regulations, 1980*, Sask. Reg. 331/79, s. 55, made pursuant to *The Hospital Standards Act*, R.S.S. 1978, c. H-10.

[25] *Hospital Management Regulations*, EC574/76 as am., made pursuant to the *Hospitals Act*, R.S.P.E.I. 1988, c. H-10.

[26] *Hospital Standards Regulations*, R.R.N.W.T. 1990, c. T-6, s. 87, made pursuant to the *Territorial Hospital Insurance Services Act*, R.S.N.W.T. 1988, c. T-3.

CHAPTER 5

RECOMMENDATIONS FOR REFORM IN CANADA

A number of law reform bodies, as well as the Uniform Law Conference of Canada, were active in the 1970s in respect of consent of minors to health care. Some of these projects led to legislative change. Others remain unacted upon. Here we summarize the main initiatives.

A. UNIFORM LAW CONFERENCE OF CANADA

In 1972, the issue of minors' consent to medical treatment was considered at the Conference of Commissioners on Uniformity of Legislation in Canada. The Conference requested the Ontario Commissioners to prepare a report for the 1973 Conference. The report was duly presented[1] and the Ontario and Québec Commissioners were asked to prepare a draft statute of general application. It appears that the primary motivating factor for this initiative was that parental consent was inhibiting young people from seeking medical assistance. It might be noted in passing that the "mature minor" rule was not as firmly established within the law in 1974 as it is now.

At the 1975 Conference, the *Uniform Medical Consent of Minors Act* was adopted.[2] As was noted earlier, only New Brunswick passed the Act with the exclusion of contraceptive treatment and advice. We canvassed the New Brunswick legislation earlier. In summary, it lowers the age of medical consent to 16 and the consent of minors under the age of 16 is valid where, in the opinion of the attending physician, the minor has the capacity to understand the nature and consequences of the medical treatment, the treatment is in the best interests of the minor and his or her continuing health and well-being and a second physician supports the attending physician's opinion on both these points.

B. INSTITUTE OF LAW RESEARCH AND REFORM OF ALBERTA

In 1975, the Institute of Law Research and Reform of Alberta (now the Alberta Law Reform Institute) issued its Report on *Consent of Minors to Health Care*.[3]

The primary recommendation of the Report was to reduce the general age of consent to medical treatment to 16. Medical treatment was defined very broadly to include contraception but specifically did not include surgical sterilization. Of much greater interest, however, was its recommendation in respect of the most difficult and controversial areas of health care relating to minors. The Institute recommended that a minor *of* any age may consent to health care in respect of any communicable disease under the *Public Health Act*, drug and alcohol abuse and prevention of pregnancy and its termination. This recommendation does not, however, exclude

[1]Uniform Law Conference of Canada, *Proceedings of the Fifty-fifth Annual Meeting* (1973) 24 and 228.

[2]Uniform Law Conference of Canada, *Proceedings of the Fifty-seventh Annual Meeting* (1975) 30 and 162.

[3]Institute of Law Research and Reform, *Consent of Minors to Health Care* (Report #19, 1975).

the parental power of consent when the patient is under 16. It was also recommended that a minor who has borne a child may consent to health care for herself and her child. The Report also stressed the confidentiality of the physician-minor relationship where the minor is able to give consent to the treatment.

In the Canadian context, the recommendation that a child of any age may consent to the treatment of venereal diseases, drug and alcohol dependency and the prevention or termination of pregnancy is unique. It was defended on the basis that, in these situations, there is a reluctance to inform parents and that the minor will be harmed by a failure to obtain treatment or delay in necessary treatment. It can also be supported on the basis that, if a minor is old enough to require treatment for such problems and is mature enough to seek treatment independently of his or her parents, then he or she is probably mature enough to give a valid consent to beneficial treatment.

The recommendation may create some difficulty by retaining the validity of parental consent. However, it should be noted that dual consent is not necessary. The consent of either will be sufficient. The only situation where conflict is likely to arise is in respect of pregnancy prevention and termination. The doctor will be protected from liability so long as the consent of one is secured. The decision to provide the treatment or not will be left to his or her professional and ethical judgment.

C. LAW REFORM COMMISSION OF SASKATCHEWAN

In Saskatchewan, work of the Law Reform Commission of Saskatchewan was preceded by an attempt to change the law in respect of a minor's consent to medical treatment by a Private Members Bill in 1973. The Bill sought to reduce the age of consent to health care, other than termination of pregnancy, to the age of 16. The debate in the Legislature divided between those who believed that those between 16 and 18 should have easier access to health care and those who saw the Bill as a direct threat to parental authority. The Bill was defeated in a free vote 22-20.[4]

The Law Reform Commission of Saskatchewan took up the issue later in the decade and, in November 1978, issued its *Tentative Proposals for a Consent of Minors to Health Care Act*.[5] The proposed Act defined health care broadly, excluding only non-therapeutic sterilization. The main provision in the Act lowered the age of consent to medical treatment to 16. This proposal reflects both the Uniform Law Conference's *Medical Consent of Minors Act* and the recommendations of the Institute of Law Research and Reform of Alberta.

The proposed Act's approach to those under the age of 16 reflects an attempt to balance the competing interests of minors, parents and health care providers. Sections 3, 4 and 5 deal with this issue. Section 3(1) sets out a general rule that those under the age of 16 may consent to medical treatment if, in the opinion of the health care provider, they appreciate the nature and consequences of the medical treatment and, after an examination of the patient, another independent health care practitioner of comparable qualification supplies a written opinion to the same effect. The remainder of section 3 addresses the parental interest in having information in respect of the child's health care. It allows any person who has a continuing relationship with the child to apply for a judicial order requiring the attending health care practitioners to disclose the nature of the health care treatment. The court, in exercising its discretion, is directed to take

[4]*An Act to Amend The Medical Profession Act*, discussed in Law Reform Commission of Saskatchewan, *Proposals for a Consent of Minors to Health Care Act* (Report, 1980) 10.

[5]Law Reform Commission of Saskatchewan, *Tentative Proposals for a Consent of Minors to Health Care Act* (Discussion Paper, 1978).

into account a wide variety of circumstances including the wishes of the minor patient, the maintenance of the health care relationship and the continuing health and well-being of the patient.

The provision allowing for disclosure must be read in relationship to section 5 which allows for any person to apply to a judge for an order prohibiting health care. Such an application must be based on reasonable grounds that the health care is not in the interests of the continuing health and well-being of the patient. Such an application may be made, for example, by a parent who, having discovered the nature of the health care being provided to a mature 15 year old, believes it not to be in the child's best interests. It may also be used where parents have consented to treatment of an immature minor and the minor or some other person does not believe it to be in the minor's best interests. The court would have an overall power to prohibit health care which is not in the best interests of minors under the age of 16.

Section 4 deals with the situation where required parental consent for treatment of an immature minor is withheld or cannot be obtained. Any person, including the minor, may apply to a judge for dispensation of that consent. The consent will be dispensed with if the judge is satisfied that withholding health care is not in the best interests of the minor.

The Act also includes an exception for emergency care and allows any person under the age of majority, who has the capacity to consent, to consent to treatment of a child in his or her custody.

Public discussion of the tentative proposals focused on two issues: the intention to fix the age of consent at 16 and the need for a supporting written opinion by a second health care practitioner in respect of mature minors under the age of 16. Some believed that there were minors between the ages of 16 and 18 who were not mature enough to make health care decisions. The need for a second written opinion as to the maturity of a minor under 16 was suggested to place an undue burden on rural doctors. There was also concern expressed about the diminution of parental authority.[6]

In February 1980, the Law Reform Commission of Saskatchewan issued a further report entitled *Proposals for a Consent of Minors to Health Care Act*.[7] The Commission did not follow through with its tentative proposals of 1978. The new draft Act sought, in the main, to codify the common law. Section 4 states:

> A minor who has the capacity to understand and appreciate the nature and consequences of health care proposed to be provided to him or her may consent to that health care.

Section 5 does allow for any person to make an application to a judge for a determination of a minor's maturity. Section 6 retains the right of any person to apply for a judicial order dispensing with parental consent and section 7 allows a person with sufficient interest to apply for a judicial order prohibiting health care on the grounds that the person has a reasonable belief that the minor lacks the capacity to understand the nature and consequences of the health care.

No action has been taken on these proposals.

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[6]Law Reform Commission of Saskatchewan, *supra* n. 4, at 11.

[7]Law Reform Commission of Saskatchewan, *supra* n. 4. Its draft Act appears at pages 12-13.

CHAPTER 6

RECOMMENDATIONS FOR REFORM IN FOREIGN JURISDICTIONS

A. ENGLAND

In 1969, the English Parliament addressed the issue of minors' consent to medical treatment. The main thrust of the *Family Law Reform Act 1969*[1] is to reduce the age of consent to 16.

Section 8 reads:

> 8. (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, 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.
>
> (2) In this section "surgical, medical or dental treatment" includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.
>
> (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

This legislation appears to create two categories of minors. First, those who are 16 and older who have the capacity of adults and, secondly, those under 16 who, under section 8(3), can give consent if they satisfy the common law test of maturity. The legislation enhances the certainty of the law in respect of 16 to 18 year olds without sacrificing the flexibility of approach to those under 16. This interpretation was adopted by the House of Lords in *Gillick* v. *West Norfolk and Wisbech Area Health Authority*,[2] a case which was discussed earlier. In that case, the House of Lords recognized that, in exceptional circumstances, a mature minor under the age of 16 could consent to contraceptive medication in the face of parental disapproval. Consequently, it appeared that there was no summary power of parental veto in respect of treatment approved of by a mature minor. Many believed that the situation would be the same in respect of the refusal of treatment by a mature minor. The concept of autonomous decision-making normally carries the power to say no as well as yes.

However, in a series of cases subsequent to *Gillick*, Donaldson M.R. adopted a different approach to section 8 in respect of cases dealing with refusal of treatment. These were the "hard cases" where parents and the medical profession were of the opinion that it was in the child's best interests to treat even in the face of the mature minor's refusal to consent. They raise the issue of the court's power and/or the parental right to override the refusal and authorize treatment. They tested the court's commitment to the right to autonomy of mature minors.

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[1] *Family Law Reform Act 1969* (U.K.), 1969, c. 46.

[2] *Gillick* v. *West Norfolk and Wisbech Area Health Authority*, [1985] 3 All E.R. 402 (H.L.).

The leading case is *Re W (a minor) (medical treatment)*[3]. In this case, a 16 year old female was under the care of a local authority. She was suffering from severe anorexia nervosa. The condition deteriorated to the point where there was some risk to her life. It was anticipated that she might, at some point, refuse treatment which the medical professionals deemed necessary to preserve her health and life.

The Court held that it had inherent power to order such treatment without her consent. This was in spite of section 8(1) of the *Family Law Reform Act 1969* which seems to indicate that a 16 year old has the same capacity as an adult. Donaldson M.R. developed his view previously given in *Re R*[4] that section 8 does not explicitly remove all parental or judicial power in respect of the medical treatment of minors. It empowers mature minors but it does not disempower the courts or parents who may provide a valid consent to treatment refused by a mature minor of any age. Donaldson M.R. stated:

> No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.[5]

Consequently, there is a residual right in the parents and the court to consent where a minor is refusing treatment in his or her best interests. The doctor will then have to decide whether or not to treat. He or she is not obliged to treat but, if consent is given by the parents, the court or persons standing in the place of parents, no liability in battery can attach to the physician.

This difficulty over the appropriate interpretation of section 8 of the *Family Law Reform Act 1969* illustrates the competing policy factors in this area of the law. The primary tension is between a paternalistic approach which gives emphasis to the preservation of life and health and the child's best interests (the welfare principle) and one which favours a child-centered right to autonomy which enhances the interests of mature minors. Donaldson M.R. favours parental over child rights and emphasizes the ultimate welfare of the child and the protection of the medical community from liability.

The English experience also provides a lesson in the importance of the language of the legislation. Section 8 is unclear and is open to different interpretations. Eventually, the House of Lords will decide between the pro-child policies of *Gillick* and the more conservative views of Donaldson M.R.

B. SCOTLAND

In 1991, the law relating to the consent of minors to medical treatment in Scotland was settled by the *Age of Legal Capacity (Scotland) Act 1991*.[6] The Act has no counterpart in England. The Act provides that any person aged 16 or over shall have legal capacity to enter into any transaction. Section 2(4) goes on to deal with persons under the age of 16. It reads:

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[3] *Re W (a minor) (medical treatment)*, [1992] 4 All E.R. 627 (C.A.).

[4] *Re R (a minor) (wardship: medical treatment)*, [1991] 4 All E.R. 177 (C.A.).

[5] *Re W (a minor) (medical treatment)*, *supra* n. 3, at 639-640.

[6] *Age of Legal Capacity (Scotland) Act 1991* (U.K.), 1991, c. 50.

A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.

This provision reflects the notion of maturity or, as it is known in the United Kingdom, "*Gillick* competence" and enshrines the common law mature minor rule. It might be noted that the legislation eschews any welfare principle by not limiting a mature minor's power to make only decisions in his or her best interests. The legislation also makes it clear that maturity is to be assessed by the doctor and cannot be second-guessed by the court so long, presumably, as he or she acts in good faith.

It is not yet clear how the view of Donaldson M.R., discussed earlier in respect of the English law, will affect the interpretation of the Scottish legislation and whether parental and court rights are fully terminated by a finding of maturity under the legislation.

C. UNITED STATES OF AMERICA

The common law of the United States on the age of consent to medical treatment is similar to that of Canada. The courts have used the concepts of emancipation, marriage and maturity to determine the power of a person under the age of majority to consent to health care. The leading test appears to be maturity.

> Several cases of long standing as well as the *Restatement of Torts* recognize the legal validity of a minor's own consent and do not insist upon the parent's consent, providing the minor is capable of understanding and appreciating the nature of the consent.[7]

However, it is difficult to generalize in respect of the United States because consent to treatment is a state matter and some decisions continue to place emphasis on emancipation and marriage as bases for a minor's autonomy. Some also place emphasis on the welfare principle that the treatment must be for the benefit of the minor.

An added complication is that the Legislatures of many states have clarified or altered the common law in respect of minors' consent.

> In addition to the strong judicial trend under common law authorizing a mature minor to give his or her own consent for all beneficial medical or surgical treatment, there have emerged a number of specific statutes in the various jurisdictions which clarify the law with respect to treatment of minors in particular situations and for particular medical conditions.[8]

The general thrust of these statutes has been to extend the rights of minors and to provide greater power to make their own health care decisions. The law in two states will be described briefly for the purposes of illustration.

[7] A.F. Southwick and D.A. Slee, *The Law of Hospital and Health Care Administration* (2nd ed., 1988) 399. See also *Prosser and Keeton on the Law of Torts* (5th ed., 1984) 115.

[8] Southwick and Slee, *supra* n. 7, at 401.

1. Mississippi

The Mississippi legislation[9] states that maturity, marriage and emancipation are sufficient to permit a minor to consent to health care. A female of any age may consent to treatment relating to pregnancy. A minor of any age can also consent to treatment for sexually-transmitted diseases. A minor who is 17 or over[10] may donate blood and minor parents may consent to treatment of their children.

2. Pennsylvania

Pennsylvania legislation[11] specifies that persons who are 18 or over,[12] persons who are married and graduates of high school give an effective consent to medical, dental and health services. In respect of sexually-transmitted diseases and treatment in respect of pregnancy, a minor of any age may consent to health care. The statute also clarifies the emergency exception allowing medical treatment of a minor of any age without parental consent when the physician believes that a delay to treatment to obtain parental consent would increase the risk to a minor's life and health.

Perhaps the most notable aspect of the American legislation is the range of procedures where a minor of any age may give a valid consent. Those procedures include the prevention, treatment and termination of pregnancy, treatment for alcohol and chemical dependency and treatment for sexually-transmitted disease. This idea of stipulating procedures to which a minor of any age may consent is also found in the Institute of Law Research and Reform of Alberta's *Report on Consent of Minors to Health Care*.

D. AUSTRALIA

The common law in Australia in respect of the power of minors to consent to medical treatment mirrors that of England and Canada. The High Court of Australia adopted the mature minor rule in *Secretary, Department of Health and Community Services* v. *J.W.B.*[13] As in other jurisdictions, there has been some legislative intervention and law reform commissions have addressed the issue. Recently the Queensland Law Reform Commission released a Discussion Paper entitled *Consent to Medical Treatment of Young People*[14] which raises many of the issues discussed in this Report. However, particular mention will be given to initiatives in South Australia and Western Australia.

1. South Australia

A decade ago, the South Australian government passed the *Consent to Medical and Dental Procedures Act, 1985*.[15] The Act declares that the consent of a young person is sufficient if the

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[9]Southwick and Slee, *supra* n. 7, at 401.

[10]Miss. Code Ann. §41-41-1 (1972) and §41-41-15 (Supp. 1974). The age of majority in Mississippi is 21.

[11]Southwick and Slee, *supra* n. 7, at 401.

[12]The age of majority in Pennsylvania is 21.

[13]*Secretary, Department of Health and Community Services* v. *J.W.B.* (1992), 175 C.L.R. 218 (H.C.).

[14]Queensland Law Reform Commission, *Consent to Medical Treatment of Young People* (Discussion Paper WP44, 1995).

[15]*Consent to Medical and Dental Procedures Act, 1985*, (No. 14 of 1985) (S. Aust.).

dentist or physician is of the opinion that the young person is mature and that the procedure is in the best interests of the young person's health and well-being. If practicable, there should be support by way of a written second opinion from another dentist or physician.

2. Western Australia

In 1988, the Law Reform Commission of Western Australia issued a Discussion Paper on *Medical Treatment for Minors*.[16] The paper contained some tentative recommendations. The primary recommendations utilized the concepts of fixed ages and presumptions of maturity. The Commission recommended that minors 16 and over should have full capacity to consent to health care without parental knowledge and consent. For the purposes of medical care, those 16 and over are deemed to be adults. A second category of minors includes those who are 13 to 15. In this category, minors are regarded as presumptively mature. They are deemed to be mature unless evidence can be adduced to show that they are in fact unable to understand the nature and consequences of the medical treatment. Children under 13 are to be regarded as potentially mature but that maturity must be established to the satisfaction of the physician. The power of a mature minor would not be subject to any parental override or veto. Furthermore, physicians would be protected from liability where the doctor reasonably believed that the child was mature or the treatment was necessary to deal with a serious threat to the life or health of the child. The latter protection would widen the common law emergency doctrine. It would protect a doctor where treatment was given to an immature minor for drug or alcohol abuse or for the treatment of sexually-transmitted disease where the common law requirement of the necessity for immediate treatment may not be met. Nevertheless, it may be inexpedient to inform parents. No welfare principle was included in the tentative recommendations.

[16]Law Reform Commission of Western Australia, *Medical Treatment for Minors* (Discussion Paper, 1988).

CHAPTER 7

PROPOSALS FOR REFORM

A. INTRODUCTION

The various legislation and reform proposals that we have canvassed evidence varying solutions to the balancing of interests which must be made in relation to the power of minors to consent to health care. The competing interests include those of the minor, the parent, the physician and the public. Each will be reviewed in turn.

The minor has two primary interests. The first is to have some degree of input and control in respect of his or her own health care which is commensurate with an objective evaluation of the minor's maturity and age. A minor may doubt that a parent can make such an objective assessment. The companion interest is the desire for unimpeded access to health care on a confidential basis in respect to matters where there may be a reluctance to inform parents and a pressing need for health care such as treatment for sexually-transmitted disease, child and sexual abuse, alcohol and drug abuse and pregnancy prevention and termination.

Parents have legal, social and moral obligations to act in the best interests of their minor children. As a child develops and matures, parental rights of control and authority diminish gradually to the point where advice and counsel replace them. Parents may be reluctant to acknowledge and accept a relinquishment of power and accept that children are deserving of a greater say in their own lives and their medical care. There may be a particular reluctance to recognize that a child has the maturity to determine what is in his or her best interests in respect of matters such as the prevention or termination of pregnancy which have moral, ethical and possibly religious dimensions. Parents may seek to maximize the degree of control over minors and will argue that even an advice and counselling role requires knowledge in respect of proposed health care.

The interest of health care providers is to provide health care which is in the best interests of the minor's welfare in a way which minimizes their exposure to legal liability. Health care providers have an overriding desire to care for their patients. They may be faced with pressing and urgent needs of very young people in the area of sexually-transmitted disease and chemical abuse. The failure to treat may have severe short- and long-term consequences for the patient. Health care workers, however, also have an understandable aversion to legal risk, primarily because of the threat to professional reputation and, secondly, because of the time, expense and anxiety produced by civil litigation. A clear and predictable legal framework is an important concern of health care providers.

The public interest is most acute in areas of sexually-transmitted disease, alcohol and drug abuse and pregnancy prevention and termination. Left untreated, these conditions often have socio-economic ramifications including criminal activities to support chemical dependencies, increased health care costs through the spread of sexually-transmitted disease, the increased cost of neglected health problems and welfare costs relating to the support of single parents. The public interest would seem to be served by increasing access to health care.

The interests are, of course, best balanced and accommodated by open communication and consensus decision-making among parents, children and health care providers. The Commission accepts that this is the best solution to these kinds of issues. However, it is the role of the legal system to provide rules or a mechanism to resolve disputes when such joint decision-making is not possible because of a breakdown of these relationships. The law must seek the most appropriate balance of interests and allocate the power of decision-making.

B. GENERAL PRINCIPLE: MATURITY OR FIXED AGE

We begin by identifying two general approaches to the issue of consent of minors to medical treatment. The first is that of the common law which favours an individualized assessment of the minor's maturity and capacity to consent. The second is to use a fixed age to determine definitively when a minor may consent to health care without parental involvement.

The mature minor rule has significant advantages. It is well known that children develop physically, intellectually and psychologically at their own unique pace. Child development is not uniform and the capacity to make responsible health care decisions is not attained at a single pre-ordained chronological age. The primary advantage of the mature minor rule is that it takes this fact into account and requires the health care provider to exercise his or her experience and professional judgment in assessing the individual patient. This determination of capacity requires a careful consideration of the individual physical, intellectual and psychological maturity of the minor, the minor's lifestyle, the nature of the parent-child relationship and the nature of the medical condition for which treatment is sought.

The notion of maturity or capacity has been favoured by the most recent legislative reform of the consent of minors to health care. Both the British Columbia *Infants Act*[1] and the Ontario *Consent to Treatment Act, 1992*[2] favour an individual assessment of maturity. There is also recognition and approval of the concept of maturity in some Manitoba legislation. *The Health Care Directives Act*[3] permits health care directives to be made by anyone with the capacity to do so. Capacity is legislatively defined as an ability to understand the information that is relevant to making a decision and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. Such a definition is reflective of and entirely compatible with the mature minor rule. The one gloss placed on the mature minor rule by the Act is a presumption of capacity if the person is 16 or older and a presumption of incapacity where the person is under 16. This presumption, being rebuttable, does not detract substantially from the core notion of maturity as the controlling concept of the power of minors to make directives for future health care. Section 25 of *The Child and Family Services Act*[4] also makes maturity the touchstone of the power of a minor who is 16 or older to refuse medical examinations and medical or dental treatment.

The disadvantage of the mature minor rule flows directly from its strength. Individual assessment breeds an inevitable degree of discretion and uncertainty. This uncertainty may be avoided by setting a fixed age of consent to medical treatment. Both Québec and New Brunswick have made use of a fixed age or a presumption. There is also some use of age categories in *The Human Tissue Act*[5] of Manitoba and presumptions in *The Health Care*

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[1] *Infants Act*, R.S.B.C. 1979, c. 196 as am. by *Miscellaneous Statutes Amendment Act, 1992*, S.B.C. 1992, c. 77, s. 2.

[2] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

[3] *The Health Care Directives Act*, C.C.S.M. c. H27, ss. 2 and 4.

[4] *The Child and Family Services Act*, C.C.S.M. c. C80, s. 25 as am. by S.M. 1995, c. 23.

[5] *The Human Tissue Act*, C.C.S.M. c. H180.

Directives Act.[6] The disadvantage to the fixed age rule is in the choice of the particular age. Much depends on the kind of medical treatment contemplated. Consent to trivial first aid would seem to be within the power of very young minors. Serious illness, giving rise to a range of treatment options, might suggest an older age. Any one age is unlikely to be appropriate to all circumstances and is unlikely to serve young people well. The issue of consent, in our opinion, demands some degree of discretion and flexibility to allow adjustment to all the relevant circumstances.

On balance, we favour the mature minor rule and reject the use of any fixed age to determine the age of consent to medical treatment. It provides sufficient flexibility and discretion to evaluate the individual minor's capacity to understand the proposed treatment, its risks and benefits and the consequences of inaction. The different pace of a child's development, the vast array of medical procedures of varying seriousness and significance and the differences in family relationships and socio-economic circumstances of children all support a process of individualized assessment.

We are supported in this conclusion by the views of some health care providers. The Commission's consultants conducted informal discussions with some selected health care providers. These persons were not members of particular organizations or institutions. They spoke as individuals whose work brings them into close contact with young people on a day-to-day basis. 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.

RECOMMENDATION 1

The concept of maturity should be maintained to determine whether or not a minor has the power to make health care decisions.

C. LEGISLATIVE CODIFICATION

The choice of maturity as the appropriate concept to govern the power of a minor to consent to medical treatment leads to the further question of whether legislative codification of that principle is appropriate. To some extent, that appears to be the current trend. Both British Columbia and Ontario have codified the maturity test in the *Infants Act* and the *Consent to Treatment Act, 1992*, respectively.[7]

Codification has certain attractions. While the mature minor rule is firmly entrenched in the Canadian common law, it has yet to receive direct approval from the Manitoba Court of Appeal and the Supreme Court of Canada. Legislation offers an opportunity for definitive declaration of the maturity standard which may be advantageous to physicians, minors and parents or guardians. Legislation also provides an opportunity to clarify some of the less certain aspects of the maturity doctrine, including the specific meaning of maturity and the power to refuse life-saving treatment.

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[6]*The Health Care Directives Act*, C.C.S.M. c. H27, s. 4.

[7]*Infants Act*, R.S.B.C. 1979, c. 196 as am. by *Miscellaneous Statutes Amendment Act, 1992*, S.B.C. 1992, c. 77, s. 2; *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

The disadvantages of codification must also be considered. Legislative wording tends to bring a new set of issues of interpretation. This is indicated by the 1992 re-enactment of section 16 of the *Infants Act* in British Columbia.[8] We discussed that legislation and pointed out a number of questions of interpretation arising from the legislative language. Legislation may also have unforeseen and unintended consequences as is indicated by the suggestion of Huddart J. in *Ney* v. *Canada (A.G.)*[9] that consultation with parents may be necessary to decide if the treatment is in the child's best interests. There is also the danger in legislation being too comprehensive and complex. The *Consent to Treatment Act, 1992*[10] in Ontario certainly raises that issue. We have little information about the experience with the Act but, as we have noted, it is already being revised by the Ontario government.

A further concern is the danger that legislation may reduce the flexibility of the law by anchoring it to inflexible language which reflects contemporary policies and values and by impeding the development of the law to deal with a variety of unforeseen and future changes in society and medical practice. This danger is best illustrated by the 1973 amendment to the British Columbia *Infants Act*[11] which quickly became dated and unreflective of changed policy and attitudes and by the New Brunswick *Medical Consent of Minors Act*[12] with its requirements of written second opinions that the person under 16 is mature and that the treatment is in the best interest of the minor and his or her continuing health and well-being. The pace of societal and medical developments create significant difficulties for legislative reform in this area and periodic review and adjustment of such legislation would seem inevitable.

Our conclusion, on balance, is that the mature minor rule should not be legislatively codified. We recognize that it has not been authoritatively approved by the Supreme Court of Canada and we recognize that certain aspects have yet to be worked out. We are comfortable, however, with the view that the mature minor rule is and will be the common law in Manitoba and that, in an incremental process, the courts will address difficult questions in a manner which best resolves the individual cases presented to them. Furthermore, the medical profession appears to be comfortable with the general notion of maturity and we are unable to identify significant problems with the current legal position. The current common law principle has a sufficient degree of flexibility and discretion to allow for the sensitive resolution of current and future questions.

RECOMMENDATION 2

The common law mature minor rule should not be put in legislative form.

D. LEGISLATIVE PROTECTION OF HEALTH CARE PROVIDERS

In Chapter 3 (Assessment of the Current Law), we identified some concerns about the mature minor rule which are common to both its legislated and common law form. We noted that, in some circumstances, the assessment of a minor's maturity may be a particularly difficult task on which opinions of health care providers may vary. This is particularly so when a young person presents himself or herself to a health care provider for the first time. We noted that,

[8] *Infants Act*, R.S.B.C. 1979, c. 196 as am. by *Miscellaneous Statutes Amendment Act, 1992*, S.B.C. 1992, c. 77, s. 2.

[9] *Ney* v. *Canada (A.G.)* (1993), 79 B.C.L.R. (2d) 47 (S.C.).

[10] *Consent to Treatment Act, 1992*, S.O. 1992, c. 31.

[11] *An Act to Amend the Infants Act*, S.B.C. 1973, c. 43.

[12] *Medical Consent of Minors Act*, R.S.N.B. 1973, c. M-6.1.

technically, a mistake in assessment may lead to a successful civil action. This raises the possibility of defensive medicine whereby the health care provider may demand parental consent in marginal or difficult cases. This, in turn, may result in unreasonable impediments to the treatment of minors which, for reasons we outlined in Chapter 3, would be unfortunate.

Recent changes in the delivery of health care increase the likelihood of minors presenting themselves to health care providers for the first time. The greater use of walk-in clinics, free-standing clinics, family planning clinics and emergency departments raise that likelihood. The issue may be complicated by the minor giving false or misleading information. In these circumstances, it is understandable if health care providers feel vulnerable to legal risk and liability. To a large degree these concerns can be addressed by providing legal protection where the health care provider has, in good faith, made a mistaken assessment of capacity. This would provide a limited degree of protection for health care providers without unduly impairing the interests of minors or parents. It may indeed further the interests of minors by reducing defensive medical practice and by enhancing access to health care. It may also, of course, in particular instances, diminish the powers of parents and guardians. However, any such diminution would be quite small.

We take the view that no action should lie in respect of giving or not giving treatment to a minor who lacks capacity if the health care provider acted in accordance with the minor's instructions and believed in good faith that the minor possessed the necessary capacity. A similar kind of protection is included in section 25(10) of *The Child and Family Services Act*[13] in favour of the agency, the hospital and the person treating the child. That protection is not, however, conditional on the requirement of good faith. We believe that this limited protection of health care providers is reasonable and appropriate given the difficulty in assessing capacity, the increased need for health care for young people and the importance of access to health care. We hasten to point out that such a protection in no way diminishes the legal obligations of care, skill and knowledge owed by health care providers or their professional and ethical duties. We recognize that this recommendation requires limited legislative intervention.

RECOMMENDATION 3

Legislation should provide that no action shall lie against any person by reason only of providing or not providing health care where the person acted in accordance with the minor's instructions and believed in good faith that the minor possessed the necessary capacity.

[13]*The Child and Family Services Act*, C.C.S.M. c. C80, s. 25(10) as am. by S.M. 1995, c. 23.

CHAPTER 8

LIST OF RECOMMENDATIONS

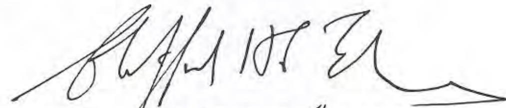
The following are the recommendations made in this Report:

1. The concept of maturity should be maintained to determine whether or not a minor has the power to make health care decisions. (p. 33)

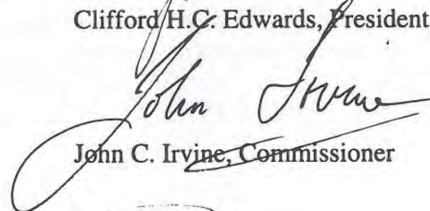
2. The common law mature minor rule should not be put in legislative form. (p. 34)

3. Legislation should provide that no action shall lie against any person by reason only of providing or not providing health care where the person acted in accordance with the minor's instructions and believed in good faith that the minor possessed the necessary capacity. (p. 35)

This is a Report pursuant to section 15 of *The Law Reform Commission Act*, C.C.S.M. c. L95, signed this 12th day of December 1995.

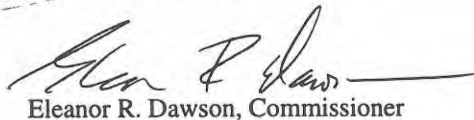


Clifford H.C. Edwards, President



John C. Irvine, Commissioner

Gerald O. Jewers, Commissioner



Eleanor R. Dawson, Commissioner

Pearl K. McGonigal, Commissioner

REPORT ON MINOR'S CONSENT TO HEALTH CARE

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

A. INTRODUCTION

The Chair of the Consent Committee of the Health Sciences Centre in Winnipeg asked the Commission to consider the issue of consent of minors to medical treatment. In particular, the Commission was asked about the advisability of legislation to clarify the law in respect of the power of persons under the age of 18 to consent to health care. This Report responds to the concerns raised by the Consent Committee.

B. THE CURRENT LAW

It is a fundamental axiom of the common law that medical examination or treatment may only take place with the full and voluntary consent of the patient. Unauthorized medical treatment is a battery and liability may be imposed whether or not an injury has occurred. This principle protects the right of every patient to personal autonomy and self-determination. An essential prerequisite to autonomous decision-making is the power to understand the nature of the illness, the alternative treatment available, the foreseeable risks and benefits of the treatment and the consequences of inaction. This cognitive ability, essential to informed and reasoned decision-making, is referred to as the patient's "capacity". Where a patient lacks capacity, some form of substitute or surrogate decision-making is necessary.

The common law has applied this notion of capacity to minors. The mature minor rule states that minors may consent to medical treatment when they understand the information relating to the medical complaint and its treatment and have an ability to foresee the consequences of the decision. Where a minor does not have this degree of maturity, parental consent is required. This is a form of substitute consent which must be given in the best interests of the child.

The mature minor rule is firmly entrenched in the common law and has been utilized in some Manitoba legislation, including *The Health Care Directives Act* and *The Child and Family Services Act*. It also appears to be well-known and accepted in the medical community.

C. RECOMMENDATIONS

The Commission recommends that the mature minor rule be maintained to determine whether or not a minor has the power to make health care decisions. It provides sufficient flexibility and discretion to evaluate the individual minor's capacity to understand the proposed treatment, its risks and benefits and the consequences of inaction. The different pace of a child's development, the vast array of medical procedures of varying seriousness and significance and the differences in family relationship and socio-economic circumstances of children all support a process of individualized assessment. The mature minor rule is a well-known, well-accepted and workable principle which raises few difficulties on a day-to-day basis. We considered the option of a fixed age rule but rejected it on the grounds that the individual development of children is too variable to permit a fixed age to be a practical and workable concept.

The Commission does not recommend that the mature minor rule be legislatively codified. We recognize that there is some uncertainty in the scope and application of the mature minor rule and that legislation may be seen as an opportunity to resolve it. On balance, however, we prefer to allow the common law to develop and evolve to resolve current and future questions about the

consent of minors. There is a danger in anchoring the law into inflexible legislative language which may be insensitive to a variety of unforeseen and future changes in society and medical practice. We are also not convinced that legislative intervention in other provinces has greatly improved this area of the law.

Finally, the Commission recommends that legislation should provide that there is no liability where a health care provider acts in accordance with the minor's instructions and believes, in good faith, that the minor has the necessary capacity to consent. We believe there are good reasons for such a good faith protection from liability. The common law is technically unforgiving of mistaken assessments of capacity, even where the assessment may be very difficult because of the circumstances under which a minor presents himself or herself for treatment. This may, in turn, lead to defensive medical practices such as demanding parental consent where it is unwarranted. Such practices may create inappropriate impediments to the treatment of minors. For these reasons, it is important that health care providers feel secure from legal risk when their assessment of capacity has been made in good faith.

SOMMAIRE DU RAPPORT

LE CONSENTEMENT DES MINEURS DES SOINS DE SANTÉ

SOMMAIRE

A. INTRODUCTION

Le Comité du consentement du Centre des sciences de la santé de Winnipeg nous a demandé, par l'entremise de son président, de nous pencher sur la question du consentement des mineurs aux traitements médicaux. Plus particulièrement, il nous a demandé de nous prononcer sur l'à-propos d'édicter des dispositions législatives pour clarifier le droit en ce qui concerne le pouvoir des personnes de moins de 18 ans de consentir à des soins de santé. Nous tentons donc, dans le présent rapport, de répondre à ses questions.

B. LE DROIT ACTUEL

Il ne peut y avoir examen ou traitement médical sans le plein et libre consentement du malade : la common law est très claire à ce sujet. Dispenser un traitement médical sans le consentement du malade constitue des voies de fait et un délit, qu'il y ait eu ou non blessure. Ce principe sert à protéger le droit de tous les malades à l'autonomie et à l'autodétermination. Il est essentiel pour prendre une décision autonome de pouvoir comprendre la nature de la maladie, les traitements de rechange possibles, les risques et les bienfaits prévisibles du traitement ainsi que les conséquences que pourrait entraîner l'absence de traitement. On appelle "capacité" du malade l'habileté mentale qui est essentielle à la prise d'une décision éclairée et rationnelle. Dans le cas des malades qui n'ont pas cette capacité, il faut recourir à une autre forme ou à une forme auxiliaire de consentement.

En common law, cette notion de capacité s'applique aussi aux mineurs. Selon la règle de la maturité-minorité, les mineurs peuvent consentir à un traitement médical pour autant qu'ils comprennent les renseignements portant sur le problème médical et son traitement et qu'ils soient en mesure de juger des conséquences de leur décision. Dans le cas des mineurs qui n'ont pas le degré de maturité voulu, il faut obtenir le consentement des parents. Il s'agit là d'une forme de consentement auxiliaire qui doit être donné dans l'intérêt supérieur de l'enfant.

La règle de la maturité-minorité est solidement enchâssée dans la common law et est utilisée dans certaines lois manitobaines, notamment dans la *Loi sur les directives en matière de soins de santé* et dans la *Loi sur les services à l'enfant et à la famille*. Elle semble également être bien connue et admise dans le milieu médical.

C. RECOMMANDATIONS

La Commission recommande que l'on maintienne la règle de la maturité-minorité pour déterminer si oui ou non un mineur a la capacité de prendre des décisions en matière de soins de santé. Cette règle offre suffisamment de souplesse et de latitude pour évaluer la capacité d'un mineur de comprendre le traitement proposé, les risques et les avantages qu'il présente et les conséquences qu'entraînerait l'absence de traitement. Le rythme de développement des enfants, le large éventail des actes médicaux, de leur gravité et de leur importance et les différences dans les rapports familiaux et les circonstances socio-économiques des enfants sont autant de facteurs qui concourent à justifier un processus d'évaluation individualisé. La règle de la maturité-minorité est bien connue, est généralement admise, constitue une solution pratique et présente peu de problèmes dans son application. Nous avons aussi envisagé la possibilité d'établir un âge

fixe, mais avons rejeté cette solution comme peu pratique et inapplicable du fait que le développement individuel diffère trop d'un enfant à l'autre.

La Commission ne recommande pas que l'on codifie dans les lois la règle de la maturité-minorité. Nous nous rendons compte qu'il existe certaines incertitudes en ce qui concerne son champ d'application et que les lois pourraient constituer une possibilité d'éliminer ces incertitudes. Mais, tout compte fait, nous avons préféré laisser la common law se développer et évoluer pour répondre aux questions actuelles et à venir au sujet du consentement des mineurs. Il y aurait un risque à couler le droit dans un langage législatif inflexible qui peut être insensible à bien des changements encore imprévus qui pourraient se produire dans la société et le milieu médical. Par ailleurs, l'expérience d'autres provinces ne nous a pas convaincus que le fait de légiférer à ce sujet ait beaucoup amélioré cette sphère du droit.

Enfin, la Commission recommande que l'on décharge, par voie législative, de toute responsabilité les fournisseurs de soins qui se conforment aux directives d'un mineur et qui croient, de bonne foi, que le mineur a la capacité de consentement voulue. Nous croyons qu'une telle disposition a sa raison d'être. La common law ne pardonne pas les erreurs d'évaluation de capacité, même si l'évaluation peut être très difficile à faire en raison des circonstances dans lesquelles un mineur se présente à un traitement. En revanche, ce genre de disposition pourrait aussi conduire à des pratiques médicales défensives, comme demander le consentement des parents même s'il n'y a pas lieu de le faire. De telles pratiques pourraient créer des obstacles indus au traitement des mineurs. Il est important que les fournisseurs de soins se sentent à l'abri de poursuites judiciaires lorsqu'ils agissent de bonne foi dans l'évaluation de la capacité.