

# **The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions**

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## Executive Summary

This research paper explores one aspect of society's construction of aging – that the maturity to make decisions comes only with age. When considering the ways in which individuals can be discriminated against on the basis of their age, we tend to focus on the experiences of older Canadians. However, minors may equally suffer discrimination simply because they are below the age of legal majority. (I use the term “minors” only to reflect society's division through law of our lifespan into childhood and adulthood, and do not intend to endorse status-based categorisation in any way). I question whether denying a minor the entitlement to make her own medical treatment decisions because of her age and *presumed* maturity may constitute discrimination within the terms of s.15 of the *Charter*.

This paper analyses the various provincial frameworks for determining whether a minor who refuses medical treatment will nevertheless receive that treatment, and contrasts these schemes with a full understanding of decision-making maturity. Some judges and statutes currently override minors' mature treatment decisions. Yet, this may simply be because judges and law-makers have been unable to reconcile themselves to compromising the protection of minors in favour of minors' autonomy when it is not clear that minors whose decisions satisfy the available tests of “maturity” have reached mature decisions.

What should we mean by “maturity”? A mature decision requires more than a high level of cognitive and psychosocial development specific to the decision-making context; a minor's mature decision is not reached in an irrational manner, and is based on a relatively stable set of informing values, which are themselves socially tolerated. I contend that minors satisfy these criteria below the age of majority, although there can be no general rules for minors of the same age. As a consequence, age is an inadequate proxy for decision-making maturity. This paper concludes with recommendations for how provincial law might be brought into line with the demands of minors' s.15 right to equal treatment, and suggests, among other proposals, the adoption of an age-based presumption of decision-making maturity for minors who are at least 12 years old.

## Biographical Notes

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# Table of Contents

<b>PART ONE: INTRODUCTION .....</b>	<b>1</b>
<b>PART TWO: A COMPARISON OF ADULTS’ AND MINORS’ LEGAL ENTITLEMENT TO MAKE HEALTH CARE DECISIONS .....</b>	<b>5</b>
<b>I. ADULTS .....</b>	<b>5</b>
<b>II. MINORS .....</b>	<b>7</b>
A. Common Law Jurisdictions .....	8
1. Health Care and Consent Legislation .....	8
2. The Common Law “Mature Minor” Doctrine .....	11
3. Child Welfare Legislation .....	15
4. The Court’s Inherent <i>Parens Patriae</i> Jurisdiction .....	19
5. Conclusion .....	21
B. Québec Civil Law .....	21
1. Minors Younger than 14 Years of Age .....	22
2. Minors Aged 14 Years and Older .....	23
3. Comparative Analysis .....	26
<b>PART THREE: A SITUATION-SPECIFIC INTERPRETATION OF JUDICIAL REASONING .</b>	<b>30</b>
<b>I. <i>REGION 2 HOSPITAL CORP. v. WALKER</i>: UPHOLDING A MINOR’S REFUSAL .....</b>	<b>30</b>
<b>II. <i>C.U. (NEXT FRIEND OF) v. McGONIGLE</i>: OVERRIDING A MATURE ADOLESCENT’S REFUSAL .....</b>	<b>33</b>
<b>III. ANALYSIS .....</b>	<b>37</b>
<b>PART FOUR: RESEARCH INTO THE NATURE OF A “MATURE” DECISION .....</b>	<b>42</b>
<b>I. MINORS’ PSYCHOLOGICAL DEVELOPMENT .....</b>	<b>42</b>
A. Cognitive Capabilities .....	42
B. Psychosocial Maturity .....	47
<b>II. NEUROSCIENCE PERSPECTIVE ON MINORS’ DEVELOPMENT .....</b>	<b>50</b>
<b>III. CONCLUSION .....</b>	<b>51</b>
<b>PART FIVE: <i>CHARTER</i> PROTECTION FOR MINORS’ MATURE HEALTH CARE DECISIONS .....</b>	<b>53</b>
<b>I. THE EXTENT OF CHARTER PROTECTION UNDER THE CURRENT LEGAL FRAMEWORK ...</b>	<b>53</b>
A. Section 2(a): The Right to Freedom of Religion .....	54
B. Section 7: The Right to Liberty and Security of the Person .....	55
C. Section 15: The Right to Equal Protection and Equal Benefit of the Law .....	56

<b>II.</b>	<b>CONCEPTUAL FRAMEWORK FOR A MINOR’S s.15 CHARTER RIGHT TO HAVE HER MATURE TREATMENT DECISION UPHOLD IN LAW .....</b>	<b>58</b>
	A. Section 15 and the Value of Autonomy .....	59
	B. Psychological Components of a Mature Decision .....	60
	C. Substantive Requirements of a Mature Decision .....	60
	D. Conclusion .....	63
<b>III.</b>	<b>SECTION 1 AND POSSIBLE JUSTIFICATIONS FOR DISCRIMINATION AGAINST MINORS’ MATURE TREATMENT DECISIONS .....</b>	<b>63</b>
	A. Administrative Efficiency .....	64
	B. Correlation Between Current Age-Based Rules and Minors’ Decision-Making Maturity.....	65
	C. Conformity with Canada’s Obligations under the <i>CRC</i> .....	68
	D. Protection of Minors’ Life and Health.....	69
<b>IV.</b>	<b>CONCLUSION .....</b>	<b>70</b>
<b>PART SIX: RECOMMENDATIONS FOR FURTHER CONSIDERATION AND LAW REFORM .....</b>		<b>71</b>
<b>I.</b>	<b>REPEAL OF AGE-BASED RESTRICTIONS AND ENACTMENT OF MATURITY-ORIENTED LEGISLATION TO GOVERN MINORS’ ENTITLEMENT TO DECIDE .....</b>	<b>71</b>
<b>II.</b>	<b>REDEFINING “MATURITY” IN MEDICAL DECISION-MAKING FOR THE PURPOSE OF HEALTH CARE AND CONSENT LEGISLATION .....</b>	<b>73</b>
<b>III.</b>	<b>LEGISLATIVE REMOVAL OF ANY CONTINUING ROLE FOR THE COURT’S INHERENT PARENS PATRIAE JURISDICTION .....</b>	<b>74</b>
<b>IV.</b>	<b>HIERARCHY OF LEGAL DOCTRINES USED TO RESOLVE WHETHER A MINOR RECEIVES MEDICAL TREATMENT .....</b>	<b>75</b>
<b>V.</b>	<b>IMPROVING MINORS’ PARTICIPATION IN THE DECISION-MAKING PROCESS .....</b>	<b>76</b>
<b>VI.</b>	<b>FURTHER RESEARCH INTO THE APPROPRIATE EXTENT OF A MINOR’S RIGHT NOT TO INFORM HER PARENTS OF MEDICAL CONSULTATIONS AND INTERVENTIONS .....</b>	<b>77</b>
<b>VII.</b>	<b>FURTHER RESEARCH INTO MEDICAL PRACTICE AND THE ROLE THAT LEGAL DOCTRINES PLAY IN “EVERYDAY” CASES .....</b>	<b>77</b>
<b>PART SEVEN: CONCLUSION .....</b>		<b>79</b>
<b>BIBLIOGRAPHY .....</b>		<b>81</b>
<b>APPENDIX A - SUMMARY OF PROVINCIAL LEGISLATION GOVERNING MINORS’ ENTITLEMENT TO MAKE HEALTH CARE DECISIONS .....</b>		<b>85</b>

## PART ONE: INTRODUCTION

Treating someone like a child is *prima facie* wrong, unless, of course, the person in question really is a child. ... To treat someone like a child is, roughly, to treat her as if her life is not quite her own to lead and as if her choices are not quite her own to make.<sup>1</sup>

B.H. has participated actively in her religious community to such an extent that I find she has lived a sheltered life... She has never been exposed to any other religious teachings... [R]eligious teachings provided to B.H. concerning blood transfusions have been dogmatic. Adherents to the faith do not question dogma or examine other points of view... B.H. has not had the life or developmental experience which would allow her to question her faith and/or its teachings and ... such experience is an essential step in arriving at a personal level of development such that she can be considered to be a mature minor who has the capacity to refuse medical treatment which is necessary to save her life.<sup>2</sup>

There are many situations in daily life in which we distinguish adults from minors, from entitlement to rent movies, to the right to vote, to smoke or to drink. These distinctions are status-based, which means that no matter how mature a 13-year-old is, for example, an Ontario movie theatre will not admit her to an “adult accompaniment” movie if she is not accompanied by an adult.<sup>3</sup>

The attribution of different statuses to minors and adults demands attention because the notion of status assumes differences *in kind* between minors and adults, rather than differences *in degree*, such as the level of maturity of the members of each age-based group. “Masters in general are more skilled than apprentices,” Schapiro explains, “but being a master does not simply consist in being a skilled apprentice. To attribute a status concept is to draw something like a distinction in kind...”<sup>4</sup> Yet, it may be that when it comes to making decisions about the

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<sup>1</sup> Tamar Schapiro, “What Is a Child?” (1999) Ethics 715 at 715.

<sup>2</sup> *B.H. (Next friend of) v. Alberta (Director of Child Welfare)*, [2002] A.J. No. 356 (Alta. Prov. Ct.), Jordan Prov. Ct. J. at paras.24–25, aff’d [2002] A.J. No. 518 (Alta. Q.B.), aff’d [2002] A.J. No. 568 (Alta. C.A.), leave to appeal to S.C.C. refused, [2002] S.C.C.A. No. 196 [*B.H.*]. B.H. was a sixteen year-old adolescent who sought to refuse chemotherapy and blood transfusions, which were necessary to treat the leukaemia from which she was suffering, on the basis of her beliefs as a Jehovah’s Witness. The Alberta Provincial Court and Court of Queen’s Bench authorised the forcible imposition of medical treatment against the adolescent’s wishes.

<sup>3</sup> *Theatres Act*, R.S.O. 1990, c. T.6, s.19(3); O. Reg. 204/04, ss.2(4), 3(1), 3(2) (amending R.R.O. 1990, Reg. 1031).

<sup>4</sup> Schapiro, *supra* note 1 at 725.

treatment of our medical conditions, we are all simply more or less skilled apprentices, minors and adults alike.

The paternalistic justification for distinguishing between minors' and adults' legal entitlement to exercise autonomy rights presumes a need to protect minors from their immaturity, and from the consequences of their immature decisions. This paper demonstrates how this reasoning blurs differences in degree with differences in kind, and causes the status-based distinction between minors and adults to become self-reinforcing. If the criteria for maturity are distilled from the nature of adulthood (e.g. using general experience over a lifetime, rather than context-specific experience as a criterion for maturity), all minors are, by definition, immature. In turn, this reinforces the validity of the status-based distinction, from which the criteria for maturity were initially derived.

This paternalistic approach to minors' decision-making maturity results from the cumulative effect of both practical concerns and unresolved theoretical tensions. There is no general agreement, for example, as to the elemental components of maturity for many spheres of activity. It is also difficult to develop tests that measure maturity; and even with these tests, it is administratively burdensome to apply any test that analyses individual components of a person's maturity.

As a consequence, provincial and federal legislatures avoid confronting these difficult issues directly, and use age as a proxy for maturity in relation to autonomy rights.<sup>5</sup> This is achieved through either absolute age-based rules of entitlement or *prima facie* age-based distinctions, which allow of certain exceptions in instances of demonstrated maturity. To this extent, age has come to be understood to signal a distinction in status, rather than merely as shorthand for an individual's degree of development; thus exceptions to *prima facie* distinctions

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<sup>5</sup> Speaking for the Ontario Court of Justice in *S.H.*, Justice Wilson states that "although capacity is to be determined based on the facts and circumstances of each case, there are milestones in our society that legislatively recognize the maturation process and the transition from child to adult. Age is resorted to in some circumstances as a proxy for capacity." See *Children's Aid Society of Metropolitan Toronto v. S.H.*, [1996] O.J. No. 2578 (Ont. Ct. J. (Gen. Div.)), Wilson J. at para.95 [*S.H.*]

are rare. Use of shorthand in legal rules permits flexibility to respond to actual maturity; status-based distinctions, on the other hand, deny the significance of the minor's actual maturity.

This research paper aims to distinguish status and maturity as separate concepts, and asks whether different legislative and common law age-based rules are a justifiable use of the age-shorthand for maturity, or if they are status-based denials of the right to decide. Part Two compares adults' freedom to make their own health care decisions to the extent of minors' decision-making rights in civil law and common law jurisdictions. I outline the four different doctrines applicable in common law jurisdictions: health care and consent legislation, the common law "mature minor" doctrine, child welfare legislation, and the court's inherent *parens patriae* jurisdiction.

I discuss these doctrines as they apply to medical treatment more generally but, perhaps somewhat inevitably, my analysis centres on adolescents' right to refuse critical medical treatment. These challenging cases question a genuine test of the judicial and legislative commitment to granting the same respect to minors' mature treatment decisions as is granted to adults.<sup>6</sup> Adolescents are in an especially difficult situation since they straddle the conceptual and definitional divide between childhood and adulthood; the age proxy is often incapable of negotiating the nuanced growth of adolescents into mature citizens.

Part Three explores the relationship between the four different doctrines available in common law jurisdictions in the leading cases of *Walker*<sup>7</sup> and *McGonigle*.<sup>8</sup> In this section, I argue that case-law outcomes depend on the prognosis and the invasiveness of the recommended medical procedure. Part Four analyses minors' psychological (cognitive, psychosocial, emotional) and neurological development. While academic commentators have

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<sup>6</sup> Manitoba Law Reform Commission, *Minors' Consent to Health Care* [Law Reform Commission of Manitoba: Winnipeg, 1995] at 5-7. See also Barry Sniderman, *Canadian Medical Law: An Introduction for Physicians, Nurses and Other Health Care Professionals* (Toronto: Carswell, 2003) at 498.

<sup>7</sup> *Region 2 Hospital Corp. v. Walker*, [1994] N.B.J. 174 (N.B.Q.B.), rev'd [1994] N.B.J. 242 (N.B.C.A.) [Walker].

<sup>8</sup> *C.U. (Next friend of) v. McGonigle*, [2000] A.J. No. 1067 (Alta. Q.B.), aff'd [2003] ABCA 66 (Alta. C.A.), leave to appeal to S.C.C. refused, [2003] S.C.C.A. No. 177 (S.C.C.), motion for reconsideration of application for leave to appeal to S.C.C. refused, 2004 SCC 12 [McGonigle].

considered minors' cognitive development in relation to decision-making maturity, this research paper presents a more comprehensive picture of minors' developing maturity. I conclude that there is sufficient evidence to support the claim that many minors can make mature treatment decisions and should be legally entitled to do so.

Part Five outlines the extent to which judges have been receptive to minors' claims to have their treatment decisions respected under s.2(a), s.7 and s.15 of the *Charter*. Using both psychological and substantive requirements to determine when a minor makes a mature treatment decision, I develop the argument that overriding a minor's mature decision violates her s.15 equality right, and contend that there is no s.1 justification for this violation. In Part Six I address various law reform proposals that flow from the need to demonstrate respect to minors' mature decisions, and that would reduce the inconsistencies of the current law.

# PART TWO: A COMPARISON OF ADULTS' AND MINORS' LEGAL ENTITLEMENT TO MAKE HEALTH CARE DECISIONS

## I. ADULTS

Every individual over the age of majority<sup>9</sup> is *prima facie* entitled to decide the course of any medical treatment she receives; health care professionals generally require a patient's "informed consent" before they can initiate or administer any treatment or intervention.<sup>10</sup> There are exceptions to this general principle, however, such as certain situations involving emergency treatment.

Since the decisions in *Malette*<sup>11</sup> and *Fleming*<sup>12</sup> it has been clear that adults possess a broad right to self-determination in relation to medical treatment, which extends to religiously-grounded refusal of treatment. In the Ontario case of *Malette*, an adult woman was involved in a serious car accident and taken to hospital while unconscious. She urgently needed blood transfusions to save her life. A doctor administered the necessary transfusions even though he knew that a card in the plaintiff's purse identified her as a Jehovah's Witness who refused all blood transfusions. The doctor continued to administer transfusions even after the plaintiff's daughter confirmed her wishes.

The treatment saved the plaintiff's life, but the Ontario High Court held the doctor liable for battery, and awarded the plaintiff \$20,000 general damages for mental distress. Judge Donnelly remarked that "[h]owever sacred life may be, fair social comment admits that certain

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<sup>9</sup> In section II, below, I explain what is meant by "the age of majority" and how its legal application varies between provinces.

<sup>10</sup> Robert M. Solomon, R.W. Kostal, Mitchell McInnes, eds., *Cases and Materials on the Law of Torts*, 5th ed. (Scarborough, On.: Carswell, 2000) at 140-154. In the absence of "informed consent," the administration of medical treatment generally constitutes a battery. There are four requirements for informed consent: first, that the patient possesses the requisite mental capacity; second, that the patient's decision is voluntary; third, that the patient's decision is informed; fourth, that the patient makes her decision without representation or fraud.

<sup>11</sup> *Malette v. Shulman* (1987), 63 O.R. (2d) 243 (H.C.J.), aff'd (1990), 72 O.R. (2d) 417 (Ont. C.A.) [*Malette*].

<sup>12</sup> *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (Ont. C.A.) [*Fleming*].

aspects of life are properly held to be more important than life itself... Refusal of treatment on religious grounds is such a value.”<sup>13</sup>

Upon appeal the Ontario Court of Appeal made clear in its judgment that, at least in relation to competent adults, the patient’s right to determine whether she receives medical treatment is based on broader principles than respect for freedom of religion alone, and is grounded in respect for individual autonomy. Justice Robins gave the right to self-determination a wide scope: “A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community.”<sup>14</sup>

In *Fleming* the Ontario Court of Appeal applied this principle outside of the religious objections context to protect the right of involuntary psychiatric patients to refuse medication – via advance instructions given while competent – in the absence of a compelling state interest in treatment being imposed. Justice Robins interpreted the common law right to self-determination as co-extensive with an individual’s right to security of the person under s.7 of the *Charter*. Justice Robins held that “[t]he doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment – any treatment – is to be administered.”<sup>15</sup> Adults’ autonomy is thus recognised in Canadian law as more important than the preservation of life and maintenance of physical health, and is protected by both the “informed consent” doctrine and the *Charter*.

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<sup>13</sup> *Malette* (H.C.J.) *supra* note 11, Donnelly J. at para.115.

<sup>14</sup> *Malette* (Ont. C.A.), *supra* note 11, Robins J.A. at 415C.

<sup>15</sup> *Fleming*, *supra* note 12, Robins J.A. at 84G.

## II. MINORS

Minors are “below the age of majority.” The age of majority embodies the shift in status from *legal* childhood to adulthood; the socially constructed “child” suddenly – upon her eighteenth or nineteenth birthday – acquires full legal responsibility for her actions, as well as many legal rights that are deeply associated with the notions of autonomy and maturity, such as the right to vote, and the right to marry without parental consent. The age of majority is 18 years of age in Alberta, Manitoba, Ontario, Québec, Saskatchewan, and Prince Edward Island;<sup>16</sup> but individuals must be 19 years old to attain the age of majority in British Columbia, New Brunswick, Newfoundland and Labrador, the Northwest Territories, Nova Scotia, Nunavut, and the Yukon.<sup>17</sup>

There are a diverse range of cases in which medical practitioners and judges must consider the extent to which minors can influence the future course of their medical treatment. A doctor may need to decide whether to accept consent given by a primary school-aged child for treatment for a broken leg, for example, if her parents are unavailable to provide the necessary consent. Or perhaps a doctor or the courts may need to determine whether to accept as valid a refusal of medical treatment made by an adolescent suffering from acute myeloid leukaemia.

Four different doctrines respond to the question of minors’ entitlement to participate in and make health care decisions in Canadian common law jurisdictions: health care and consent legislation, the common law “mature minor” doctrine, child welfare legislation, and the court’s inherent *parens patriae* jurisdiction. The nature of each of these doctrines varies according to provincial legislation and case-law. The Québec position can be found in various

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<sup>16</sup> *Age of Majority Act*, R.S.A. 2000, c. A-6, s.1; *Age of Majority Act*, C.C.S.M., c. A7, s.1; *Age of Majority and Accountability Act*, R.S.O. 1990, c. A.7, s.1; *Age of Majority Act*, R.S.P.E.I. 1974, c. A-3, s.1; CCQ, *infra* note 18, Art.153; *Age of Majority Act*, R.S.S. 1978, c. A-6, s.2.

<sup>17</sup> *Age of Majority Act*, R.S.B.C. 1996, c.7, s.1(1); *Age of Majority Act*, R.S.N.B. 1973, c. A-4, s.1(1); *Age of Majority Act*, S.N.L. 1995, c. A-4.2, s.2; *Age of Majority Act*, R.S.N.W.T. 1988, c. A-2, s.2; *Age of Majority Act*, R.S.N.S. 1989, c. 4, s.2(1); *Age of Majority Act*, R.S.N.W.T. 1988, c. A-2, s.2; *Age of Majority Act*, R.S.Y. 2002, c. 2, s.1(1).

provisions of the *Civil Code of Québec*<sup>18</sup> and provincial child welfare legislation; the Québec approach also responds to underlying themes present in the different common law doctrines. The discussion that follows considers the common law and civil law approaches in turn, and outlines the extent to which minors of different ages are able to influence decisions made about their health care. Appendix A contains a chart that compares the general approach between the provinces.

## A. Common Law Jurisdictions

### 1. Health Care and Consent Legislation

When a minor asks that her medical treatment decision be respected, health care providers are guided first and foremost by provincial health care and consent legislation. Far from adopting a common solution, provincial approaches vary greatly. This section explores the provinces' different responses as revealed in health care legislation: "best interests" models, capacity-based models, and age-based presumptions.

**"Best Interests" Models:** British Columbia and New Brunswick focus on a minor's "best interests" to determine her entitlement to make health care decisions;<sup>19</sup> New Brunswick's approach also incorporates an age-based presumption of capacity. The "best interests" requirement restricts access to health care decision-making for minors who have already demonstrated their capacity to make the particular decision in question. Thus the British Columbia *Infants Act* states that a minor of any age is not entitled to consent to treatment, unless she is judged a capable decision-maker *and* the contemplated treatment "is in the infant's best interests."<sup>20</sup>

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<sup>18</sup> *Civil Code of Québec* [CCQ].

<sup>19</sup> See *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1 [*Medical Consent of Minors Act*]; *Infants Act*, R.S.B.C. 1996, c. 223, s.17 [*Infants Act*].

<sup>20</sup> *Infants Act*, *ibid* at s.17.

The “best interests” requirement in the New Brunswick *Medical Consent of Minors Act* may be more restrictive than the British Columbia provision. Section 3(1)(b) of the New Brunswick Act provides that not only must the contemplated health care be in the “best interests of the minor,” but it must also be in the “best interests of ... his continuing health and well-being.”<sup>21</sup> It is unclear what purpose this second requirement serves other than as a further restriction. In addition, Justice Ryan suggested, *obiter*, in *Walker* that this additional requirement means minors younger than 16 years of age who have been held entitled decision-makers under s.3, may only make decisions in relation to non-life threatening situations or, at least, treatments from which there would be a positive result.<sup>22</sup>

Yet the New Brunswick Act grants minors aged 16 or older *greater* decision-making authority than many other provinces. Section 2 of the Act adopts an **age-based presumption** of entitlement to make medical treatment decisions: all minors who are 16 years old or older are entitled to consent to (and presumably refuse)<sup>23</sup> medical treatment as *if* they had reached the age of majority. Section 17 of the British Columbia *Infants Act*, by contrast, applies the “best interests” restriction on entitlement to decide to minors of all ages. Section 17 may also imply an absolute rule against any minor being entitled to refuse health care since s.17(3) refers to “[a] request for consent, agreement or acquiescence to health care...” This list of types of participation in decision-making to which a minor may become entitled implies the exclusion of entitlement to refuse treatment.<sup>24</sup>

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<sup>21</sup> *Medical Consent of Minors Act*, *supra* note 19 at s.3(1)(b).

<sup>22</sup> *Walker*, *supra* note 7, Ryan J.A. at para.53.

<sup>23</sup> I draw this inference from the wording of s.2 *Medical Consent of Minors Act*. Section 2 reasons:

The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority.

In stating that the “law respecting consent” applies “in all respects” to minors who have attained 16 years of age, such a broadly worded provision must surely include the authority to refuse treatment.

<sup>24</sup> Or, expressed in more succinct terms, *expressio unius est exclusio alterius*.

**Capacity-Based Models:** Both Ontario and Prince Edward Island's health care and consent statutes focus on minors' "capacity" to make medical treatment decisions<sup>25</sup> and do not specify an age at which minors may argue that they are "capable."<sup>26</sup> These provincial statutes thereby entitle "capable" minors of any age to make health care decisions. Because both provincial statutes presume decision-making "capability," the onus is on child welfare and health authorities to demonstrate otherwise. Section 4(1) of the Ontario *Health Care Consent Act* defines a "capable" decision-maker as an individual who:

... is able to understand the information that is relevant to making a decision about the treatment... and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

In the absence of judicial interpretation the s.4(1) "capability" requirement seems very similar to the current conception of the "mature minor," a notion that is explored in the discussion that follows.

**No Health Care and Consent Legislation:** Provinces that do not have legislation that addresses minors' entitlement to make health care decisions include Manitoba, Newfoundland and Labrador, Saskatchewan, Alberta, and Nova Scotia. But the potential for minors to make their own treatment decisions varies between these provinces. In Manitoba, Saskatchewan, and Newfoundland and Labrador, minors who are at least 16 years old are presumed capable of acting as or appointing substitute decision-makers.<sup>27</sup> These provisions may influence the interpretation and application of the common law "mature minor" doctrine.

Minors in Nova Scotia may also be able to avail themselves of the common law rule, although the *Medical Consent Act*<sup>28</sup> cannot be relied on as support for this proposition since

<sup>25</sup> *Health Care Consent Act*, S.O. 1996, c.2, Sch.A. [*Health Care Consent Act*], *Consent to Treatment and Health Care Directives Act*, R.S.P.E.I. 1999, c. C-17.2 [*Consent to Treatment and Health Care Directives Act*].

<sup>26</sup> Both the Ontario and Prince Edward Island's statutes presume every "person" a capable decision-maker, without distinguishing between minors and adults. See *Health Care Consent Act*, s.4(2), *Consent to Treatment and Health Care Directives Act*, s.3(1).

<sup>27</sup> See e.g. *Health Care Directives Act*, C.C.S.M. 1992, c. H27, s.4(2); *Advance Health Care Directives Act*, S.N.L. 1995, c. A-4.1, s.7; *Health Care Directives and Substitute Decision Makers Act*, S.S. 1997, c. H-0.001, s.3.

<sup>28</sup> R.S.N.S. 1989, c. 279, s.3(1).

only legal adults are thereby entitled to make advanced health care directives. In Alberta, the absence of entitlement-conferring legislation has led to Alberta courts interpreting the *Child Welfare Act* as the final arbiter of whether or not a minor receives recommended medical treatment.<sup>29</sup>

**Conclusion:** There is no consensus between provinces as to which health care model is most appropriate for determining minors' entitlement to make treatment decisions. As a result, it is much more difficult for health care providers, who must confront this dilemma in very difficult circumstances, to be confident in any decision they reach. Their dilemma is worsened by both the legislative failure to define concepts central to their decision (e.g. "best interests" and "consent") and the lack of judicial clarification of these issues. Are a minor's "best interests" being pursued, for example, if the proposed treatment would leave her physically well, but feeling spiritually violated? Does "consent" include refusal of treatment? That only some provinces feel it necessary to employ an age-based rule (rather than an age-based presumption, or capacity-oriented rule) suggests that such continued use of age-based rules may now be more a matter of policy than of administrative shorthand for capacity.

## 2. The Common Law "Mature Minor" Doctrine

Early case-law that addressed minors' entitlement to make health care decisions focussed on their common law authority. Judges in these early cases presumed in their reasoning that the common law did not prescribe a minimum age for entitlement to consent. While the early Ontario case of *Booth*<sup>30</sup> turned on the application of the common law "emancipated minor" rule,<sup>31</sup> it is the common law "mature minor" doctrine that has become the dominant common law

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<sup>29</sup> See *B.H.*, *supra* note 2; *McGonigle*, *supra* note 8.

<sup>30</sup> *Booth v. Toronto General Hospital* (1910), 17 O.W.R. 118 (Ont. K.B.) [*Booth*].

<sup>31</sup> The "emancipated minor" doctrine entitles minors who are emancipated from parental control and guidance treats them as if they were legal adults in many respects, which includes the entitlement to make their own medical treatment decisions.

framework for analysis.<sup>32</sup> In a sense, the “mature minor” principle represents a parallel regime to statutory health care and consent legislation; both doctrines may achieve the same result. Thus, if a health care provider judges her minor patient a “mature minor” at common law, she may treat the minor without needing to consult the minor’s parents, child welfare authorities, or the court.

Whether the “mature minor” doctrine assists minors who wish to make their own health care decisions, depends upon the sphere of operation left to it within provinces’ developing legislative frameworks. In Ontario and Prince Edward Island, for example, the persistence of the common law rule seems to add little to minors’ legislative entitlement to make treatment decisions. These provinces base entitlement on the demonstration of a decision-making capacity, which is set out in very similar terms to the common law doctrine. The absence of any legislative provisions makes the “mature minor” doctrine the only means for minors in Nova Scotia to become entitled decision-makers. By contrast, since minors in Newfoundland and Labrador are exempt from the application of the *Child, Youth and Family Services Act* if they are at least 16 years old,<sup>33</sup> it is only those minors aged 15 or younger that must rely on “mature minor” arguments to gain entitlement to make treatment decisions in that province.

Speaking for the Alberta Court of Queen’s Bench in *B.H.*,<sup>34</sup> Justice Kent defines a “mature minor” in very similar terms to statutory definitions of “capacity.”<sup>35</sup> Justice Kent states that “... mature minor status requires ... intelligence to do the analysis, not that it has been done.”<sup>36</sup> This suggests that the Canadian approach favours a different approach to that of English law, the origin of the “mature minor” doctrine.<sup>37</sup> The English interpretation requires that the minor actually analyse her situation in a particular way before being declared a “mature”

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<sup>32</sup> See e.g., *Johnston v. Wellesley Hospital* (1971), 2 O.R. 103 (Ont. H. Ct.), *J.S.C. and C.H.C. v. Wren* (1986), 76 A.R. 118 (Alta. Q.B.), aff’d (1987), 76 A.R. 115 (Alta. C.A.), *Re L.D.K.* (1985), 48 R.F.L. (2d) 164 (Ont. Prov. Ct.) [*L.D.K.*].

<sup>33</sup> *Child, Youth and Family Services Act*, S.N.L. 1998, C-12.1, s.2(1)(d).

<sup>34</sup> *B.H.*, supra note 2.

<sup>35</sup> See e.g. *Health Care Consent Act*, supra note 25, s.4(1).

<sup>36</sup> *B.H.* (Alta. Q.B.), supra note 2, Kent J. at para.36.

<sup>37</sup> *Gillick v. West Norfolk & Wisbech Area Health Authority*, [1986] 1 A.C. 112 (H.L. (Eng.)) [*Gillick*].

decision-maker,<sup>38</sup> namely that she make “maximally autonomous decision[s].”<sup>39</sup> Justice Kent suggests that it is enough for minor in Canada to be merely a (sufficiently) capable decision-maker.

The Canadian common law test for capable decision-making focuses on a minor’s cognitive development. In *Re Koch*, Judge Quinn stated that the necessary “capacity is a cognitive capacity. It involves the functions of understanding and appreciation as they relate to [the proposed medical treatment].”<sup>40</sup> This cognitive interpretation of maturity is highly problematic. Although a cognitive definition of “capacity” captures what was at one time our comprehensive understanding of the nature of good decision-making, we now recognise that it provides only a partial account. Thus the extent to which both a minor is influenced by the opinion of others – her psychosocial maturity – and her decision-making is affected by her illness, we now understand to be issues central to any accurate assessment of decision-making ability.<sup>41</sup>

The persistence of any form of the common law rule is not uncontroversial in certain Canadian jurisdictions, hence the “mature minor” doctrine may empower minor decision-makers only as long as it endures in the face of pressure from both legislative developments and the judicial desire to authorise medically necessary health care. Various Alberta courts have held that the common law rule has been superseded by provincial child welfare legislation.<sup>42</sup> Yet, in the leading Manitoba case of *Kennett Estate*,<sup>43</sup> Chief Justice Scott declared that the “mature minor” rule persists alongside Manitoba’s new child welfare legislation.<sup>44</sup> The authority of the “mature minor” doctrine is also called into question by judicial *dicta* that suggest a “mature”

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<sup>38</sup> See e.g. *Gillick, ibid.*, Lord Scarman at 189; *Re E*, [1993] 1 FLR 386 (H.C.), Ward J. at 393D.

<sup>39</sup> John Harris, *The Value of Life* (London, U.K.; Boston, Ma.: Routledge & Kegan Paul, 1985) at 200-201.

<sup>40</sup> *Re Koch*, [1997] O.J. No. 1487 (Ont. Gen. Div.), Quinn J. at para.32 [*Re Koch*].

<sup>41</sup> Further implications of a cognitive-only conception of the “mature minor” doctrine are explored in Part Four.

<sup>42</sup> See e.g. *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at para.31; *McGonigle* (Alta. Q.B.), *supra* note 8, Clarke J. at para.22, (Alta. C.A.), Russell J.A. at para.35. The legislative development in question is the *Child Welfare Act*, R.S.A. 1984, c. C-8.1, currently in force as the *Child Welfare Act*, R.S.A. 2000, c. C-8.

<sup>43</sup> *Kennett Estate v. Manitoba (Attorney-General)*, [1998] M.J. No. 337 (M.C.A.) [*Kennett Estate*].

<sup>44</sup> *Ibid.*, Scott C.J.M. at para.48. The legislative development in question is the *Child and Family Services Act*, S.M. 1985-86, c. 8, especially s.25(9). I address this contentious issue in more detail in subsection 3, below.

minor's treatment decision may be overridden by the court's exercise of its inherent *parens patriae* jurisdiction.<sup>45</sup>

Two other important issues remain unresolved in relation to the "mature minor" doctrine. First, there is no consensus across Canadian common law jurisdictions as to whether the "mature minor" doctrine encompasses both consent to and refusal of treatment, or consent exclusively.<sup>46</sup> It is unclear whether the same uncertainty extends to non-life-threatening health care because this issue has been debated in cases concerned with potentially life-saving medical treatment. If it were generally accepted that the common law rule applied to consent to treatment only, the idea of the doctrine as a tool for the empowerment of minors would be undermined, especially since it would highlight that policy could trump legally recognized maturity: why else would capable minors be permitted to consent to treatment recommended by health care practitioners, but not, despite their capability, to refuse that same treatment?

Second, it is unclear whether the common law rule grants exclusive decision-making authority to minors, or whether it makes their entitlement merely concurrent with the authority held by their parents.<sup>47</sup> If the latter position became accepted, a "mature" minor would be entitled to consent to treatment, but would be liable to have her refusal of treatment overridden by parental consent. But, if the "mature minor" doctrine were held to encompass consent to treatment alone, uncertainty surrounding the possibility of concurrent entitlement would lose its potential significance.

This discussion has identified various difficult issues that persist with the interpretation and application of the "mature minor" doctrine: the inadequacy of its cognitive test for maturity;

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<sup>45</sup> See subsection 4 below.

<sup>46</sup> In favour of a "mature minor" being entitled to both consent to and refuse potentially life-saving medical treatment: *Walker* (N.B.C.A.), *supra* note 7, Hoyt C.J.N.B. at para.23; Sneiderman, *supra* note 6 at 48; Jennifer L. Rosato, "The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?" (1996) 49 Rutgers L. R. 1 at 7-8. Against entitling a "mature minor" to refuse potentially life-saving medical treatment: *Walker* (N.B.C.A.), *supra* note 7, Ryan J.A. at paras.52-58 (although his views could be confined to the facts before him). Issue left open: *McGonigle* (Alta. C.A.), *supra* note 8, Russell J.A. at para.31.

<sup>47</sup> In favour of the view that the "mature minor" is the sole entitled decision-maker: *Van Mol* (*Guardian ad litem of*) v. *Ashmore*, [1999] B.C.J. No. 31 (B.C.C.A.), Huddart J.A. at paras.142-43, Lambert J.A. at paras.75, 89. In favour of the view that a "mature" minor shares decision-making authority with her parents: *McGonigle* (Alta.Q.B.), *supra* note 8, Clarke J. at para.24. Unclear: *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at paras.31-44.

uncertainty as to whether the “mature minor” rule has been superseded by child welfare legislation, or can be overridden by the court’s exercise of its inherent *parens patriae* jurisdiction; uncertainty as to whether the doctrine extends to include both refusal of and consent to treatment, or consent alone; and uncertainty as to whether a parent can consent to treatment that a “mature” minor has refused. The common law doctrine little assists minors, health care providers, parents or lower court judges in anticipating the appropriate legal response to a minor’s so-called “mature” refusal of treatment.

### **3. Child Welfare Legislation**

Provincial child protection provisions may determine whether a minor receives proposed medical treatment if the two previously-discussed doctrinal approaches have not already resolved the question. Several different circumstances may bring child welfare provisions into consideration. For a younger minor who is plainly too immature to make her own treatment decision, or for an adolescent minor whose competency is doubted by her physician, child welfare legislation becomes important when the physician disagrees with her parents’ decision.<sup>48</sup>

For a capable adolescent minor, the extent to which child welfare legislation affects her future medical treatment is determined by provincial health care and consent legislation together with the “mature minor” doctrine. If an adolescent is held a capable decision-maker within the terms of consent legislation, child welfare provisions are irrelevant. If the adolescent can be held a capable decision-maker at common law only, certain provincial child welfare authorities may seek to override her decision and ignore her “mature minor” status if they disagree with the consequences of her decision.

When it determines whether treatment should be administered to a minor, the court must satisfy itself that she is in need of protection and, furthermore, that her “best interests” would be

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<sup>48</sup> See *e.g. B.(R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 (S.C.C.) [B.(R.)].

met by authorising treatment to proceed. It is not clear by what test or standard a court should determine whether receiving any particular medical procedure is in a minor's "best interests." The statutory lists of factors to be considered in making this determination offer little more than a structure for the exercise of judicial discretion; the "best interests" criterion suffers from the problem of indeterminacy.<sup>49</sup> On the right facts, therefore, it may be that a court would place increased emphasis on a minor's opinion, her emotional well-being as well as physical needs, and so forth. The fact that some judges tend to view physical health as the paramount concern,<sup>50</sup> whereas others may take a more holistic approach and consider spiritual wellness equally important,<sup>51</sup> demonstrates the uncertainties inherent in the "best interests" standard.

The same concerns that make it hard to assess a minor's "best interests" add uncertainty to the inquiry into what constitutes "proper medical treatment." Should "proper" treatment be assessed exclusively on its chances for improving the patient's physical well-being? Or should other aspects of the patient's circumstances influence whether treatment is authorised, such as the effect of treatment upon her religious beliefs? In the Ontario case of *L.D.K.*, 12-year-old L was diagnosed with acute myeloid leukemia, and doctors thought her chances of survival were not much greater with chemotherapy and transfusions than without (between 30 and 10 percent). In determining whether treatment was necessary, Judge Main reasoned that, "[w]ith this patient, the treatment proposed by the hospital addresses the disease only in a physical sense. It fails to address her emotional needs and her religious beliefs. It fails to treat the whole person."<sup>52</sup>

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<sup>49</sup> On the issue of indeterminacy in the application of the "best interests" test, see e.g. Philip Alston and Bridget Gilmour-Walsh, *The Best Interests of the Child: Towards a Synthesis of Children's Rights and Cultural Values* (Florence, Italy: International Child Development Centre, 1996), reprinted in Miguel Angel Verdugo and Víctor Soler-Sala, eds., *La Convención de los derechos del niño hacia el siglo XXI* (Salamanca, Spain: Ediciones Universidad Salamanca, 1996) 253-290.

<sup>50</sup> See e.g. *B.H.* (Alta. Prov. Ct.), (Alta. Q.B.) *supra* note 2.

<sup>51</sup> See e.g. *L.D.K.*, *supra* note 32. Though *L.D.K.* was actually concerned with the definition of "proper medical treatment," Judge Main's reasoning applies equally to the proper determination of a minor's "best interests."

<sup>52</sup> *L.D.K.*, *supra* note 32, Main Prov. Ct. J. at para.21. See also *Re K.P.*, [1996] 4 W.W.R. 748 (Sask. Prov. Ct.) [*K.P.*]. The question for the court in *K.P.* was whether it should authorise a liver transplant for an infant, who was just a few months' old. Without the transplant, death would follow as a certainty. With the transplant, there would be a 70-75 percent one-year survival rate, and a 60-65 percent five-year survival rate. The infant would never have a

The intersection of child welfare statutes with both consent legislation and the “mature minor” doctrine, did not receive much legislative attention during the enactment of broad provincial child welfare provisions. As a consequence, the provincial statutes provide no indication of their intended place within the scheme of doctrinal approaches to minors and medical treatment. Section 37(2) of the Ontario *Child and Family Services Act*, for example, states:

- (2) A child is in need of protection where,
- ...
- (e) the child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child’s parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

A plain language reading of s.37(2) suggests that a minor held capable under either consent legislation or the common law doctrine may also be “in need of protection” and suffer her decision to be overridden if she has decided to refuse treatment with the support of her parents.

Yet, such a result would undermine the essential purpose of the entitlement to decide that consent legislation may grant to the minor. To avoid this result, we may choose to “read in” a provision to the *Child and Family Services Act*, which would provide for the *Health Care Consent Act* to take priority. “Reading in” is defensible as a matter of theory: in the medical treatment context, child welfare legislation enables the state to protect minors from parental neglect and ill-treatment. When a minor becomes an entitled decision-maker within the terms of consent legislation, her parents’ wishes vis-à-vis the proposed treatment are rendered irrelevant

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normal life, however, and would be highly susceptible to infections, and suffer a distinctly reduced quality of life. The preponderance of expert opinion accepts that the parents’ refusal of the transplant is acceptable in the circumstances, though the Minister of Social Services argues that the transplant was in the infant’s “best interests.” Judge Arnot concludes that the parents’ refusal should be respected, and states:

The surgery option offers a probability of prolonging life for an uncertain period with a reduced quality. The emotional, social and psychological cost to the child and the family may be high. The decision to be made cannot be reduced to mere mathematical probabilities.

Can it be said that this is a clear case of rejection by the parents of the values society expects of thoughtful, caring parents for a terminally ill child? In my opinion, in this case the question must be answered in the negative.

See *K.P.*, Arnot Prov. Ct. J. at 755. While the question in *K.P.* was put in the language of the infant’s “best interests,” Judge Arnot’s reasoning focused as much on the issue of what further medical treatment it was proper for the infant to receive – supportive, palliative care or a potentially life-prolonging transplant?

– the minor herself makes the decision. As a consequence, the belief of a minor’s parents that it is right to refuse treatment should not trigger child protection mechanisms.

An identical argument exists in relation to the “mature minor” doctrine: once the minor is held “mature” at common law, there is no legitimate role for child welfare provisions. This understanding of the connection between the common law doctrine and child welfare legislation also accords with the principle of statutory interpretation that legislation is generally intended to supplement, not supplant, common law rules or remedies.<sup>53</sup> This analysis casts doubt on the correctness of the Alberta courts’ current position<sup>54</sup> that the enactment of the Alberta *Child Welfare Act* removed any sphere of operation for the “mature minor” doctrine, despite the absence of any clear legislative intent to this effect.

The Alberta approach has serious implications for minors’ entitlement to make medical treatment decisions. Using child welfare provisions to override “mature” minors’ decisions would make the age of majority the *de facto* minimum age for entitlement to make health care decisions.<sup>55</sup> Further, the Alberta approach would introduce significant doctrinal inconsistencies if it were followed in other jurisdictions. By providing that a “mature” minor’s decision may be overridden unless she is also adjudged capable within the terms of health care and consent legislation, the Alberta approach falsely distinguishes between the common law “mature minor” doctrine and its statutory equivalent.

This discussion reveals significant tensions that need to be clarified if child welfare statutes are to play a legitimate role in determining the scope of older minors’ entitlement to decide the course of their own medical treatment. Otherwise, legislative provisions designed to

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<sup>53</sup> See Ruth Sullivan, *Statutory Interpretation* (Toronto: Irwin, 1997) c. 14(B) (QL).

<sup>54</sup> See *B.H.*, *supra* note 2; *McGonigle*, *supra* note 8.

<sup>55</sup> A limited exception applies to this *de facto* child welfare rule that no person below the age of majority may make her own treatment decisions without the approval or acquiescence of provincial child welfare authorities. In Ontario, for example, child welfare authorities are only entitled to intervene to protect the child until the age of majority (18 years) if the minor has not previously been subject to a protection order while she was younger than 16 years of age. If there has been no such previous involvement, child welfare authorities may not intervene once the minor reaches age 16. This is made clear in the definition of “child” in s.37(1) of the *Child and Family Services Act*, RSO 1990, c. C.11.

protect younger minors from neglect and abuse may result in imposing arbitrary restrictions upon the autonomy of older minors.

#### 4. The Court's Inherent *Parens Patriae* Jurisdiction

*Parens patriae* literally means “parent of the country.”<sup>56</sup> In its modern form *parens patriae* underpins judicial action that “act[s] for the protection of those who cannot care for themselves.”<sup>57</sup> Since its development out of the wardship jurisdiction, the predominant aim of *parens patriae* has been to protect minors when there are no parents or guardians to act in the minor’s “best interests,” or when the court disagrees with parental decisions made on a minor’s behalf. In this sense, exercise of the court’s inherent jurisdiction is akin to a court order issued under the authority of a child welfare statute, though the proper role of the former tends to be to fill gaps in the protective regime of the latter.<sup>58</sup>

The *parens patriae* jurisdiction can be particularly useful in relation to infants, young children, and certain older children who are plainly incapable of making complex determinations of their own “best interests,” and whose parents have made harmful decisions on their behalf. Given the comprehensive drafting of modern child welfare provisions and substitute decision-maker rules, however, it is unlikely that there will be many cases in which a legislative gap justifies the court’s reliance on its inherent jurisdiction.<sup>59</sup>

As regards older minors, there are controversial judicial statements to the effect that a court can exercise the inherent jurisdiction to override a “mature” minor’s treatment decision if

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<sup>56</sup> *Walker* (N.B.C.A.), *supra* note 7, Ryan J.A. at para.54. Theobald writes that the origin of the court’s *parens patriae* jurisdiction is “lost in the mists of antiquity.” See H.S. Theobald, *The Law Relating to Lunacy* (London, U.K.: Stevens & Sons, 1924) at 1. The jurisdiction arose out of the English King’s duty to provide for disabled persons. *Parens patriae* was initially employed mainly by the Court of Chancery as an equitable doctrine to protect the property of persons who lacked full legal capacity, but its rationale clearly applied to minors. After the abolition of the Court of Wards, the Court of Chancery assimilated the care of minors into their exercise of *parens patriae*.

<sup>57</sup> *Re Eve*, [1986] 2 S.C.R. 388 (S.C.C.), LaForest J. at para.32.

<sup>58</sup> *B. (D.) v. Newfoundland (Director of Child Welfare)*, [1982] 2 S.C.R. 716, Wilson J. at 724. See also *G. (C.) v. Children’s Aid Society of Hamilton-Wentworth* (1998), 39 R.F.L. (4th) 389 (Ont. C.A.); *R.L. v. Children’s Aid Society of the Niagara Region*, [2002] O.J. No. 4793 (Ont. C.A.), aff’g [2002] O.J. No. 4481 (Ont. Sup. Ct.).

<sup>59</sup> One situation in which the *parens patriae* jurisdiction may at first glance seem useful is when incapable older minors refuse medical treatment and they are too old for first time intervention under provincial child welfare provisions. But this situation may be resolved by straightforward application of substitute decision-maker rules.

the provision of health care would “protect” that minor.<sup>60</sup> But the jurisdiction has not yet been exercised in this manner.<sup>61</sup> Madam Justice Russell’s recent comments in the Alberta Court of Appeal in *McGonigle* cast doubt on the legitimacy of a future judge’s use of *parens patriae* to override a “mature” minor’s decision.<sup>62</sup> Madam Justice Russell remarked that “a court may be unable to exercise its *parens patriae* jurisdiction with respect to a mature minor who is no longer in need of protection from the court...”<sup>63</sup>

The aim of the inherent jurisdiction justifies Madam Justice Russell’s doubts. Once a minor is “mature” enough to make a particular treatment decision, whether as a matter of common law or within the terms of health care and consent legislation, she should be entitled to have her decision accorded the same respect in law as an adult’s decision. Adults are outside the protection of the court in the health care decisions they make.<sup>64</sup> The notion of the “mature” minor, whether at common law or under health care and consent legislation, intends to similarly position adolescents outside the protection of the court. But there is no sound distinction between the nature of the “maturity” that satisfies the common law standard, and the “maturity” required by applicable legislative provisions. As a consequence, if the *parens patriae* jurisdiction were to be used by the courts to protect “mature” minors, it would render health care and consent provisions superficially inconsistent with common law doctrines; on a more profound level, if *parens patriae* were exercised as a veto power over minors’ mature decisions, this would undermine the purpose of valid (health care and consent) legislation. The *parens*

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<sup>60</sup> See e.g. *Walker* (N.B.C.A.), *supra* note 7, Ryan J.A. at para.61, Angers J.A. at para.40; *Ney v. Canada (Attorney General)* (1993), 102 D.L.R. (4th) 136 (B.C.S.C.), Huddart J. at 146; *Van Mol*, *supra* note 47, Huddart J.A. at para.143. But see: *Walker* (N.B.C.A.), *supra* note 7, Hoyt C.J.N.B at para.26, 29, and the discussion of *McGonigle* in the Alberta Court of Appeal in this subsection, in which Madam Justice Russell hesitantly disapproves of the according the *parens patriae* jurisdiction overriding status.

<sup>61</sup> An English court, in contrast, has employed the inherent jurisdiction as part of its *ratio decidendi* to override an adolescent’s refusal of potentially life-saving medical treatment, on the basis that this use of *parens patriae* was in the adolescent’s “best interests.” See *South Glamorgan County Council v. W and B*, [1993] 1 FLR 574. See also judicial dicta to this effect in *Re R (A Minor) (Wardship: Consent to Treatment)*, [1992] 1 FLR 190 (C.A.); *Re W (A Minor) (Medical Treatment: Court’s Jurisdiction)*, [1993] Fam. 64 (C.A.); *Re C (Detention: Medical Treatment)*, [1997] 2 FLR 180 (H.C.).

<sup>62</sup> *McGonigle* (Alta. C.A.), *supra* note 8, Russell J.A. at para.33.

<sup>63</sup> *Ibid.*

<sup>64</sup> Apart from adults who have been shown to be “incapable,” of course.

*patriae* jurisdiction has a detrimental impact only upon the limited decision-making authority elsewhere secured to adolescents.

## 5. Conclusion

This analysis of the four doctrines that apply in common law jurisdictions reveals the uncertainties and inconsistencies that characterise the current Canadian legal regime. Key concepts continue to lack clear definitions, which increases the appearance – if not also the reality – of a lack of transparency in judicial reasoning. The absence of a clear map of the interrelationship between the four different doctrinal approaches makes it difficult for minors, their parents or health care providers to predict the outcome of legal and judicial involvement in their case. The lack of reasoned analysis or attempted justification for huge variations in outcomes between different provincial frameworks hints that arbitrary age-based and paternalistic concerns may underpin provincial regimes, rather than the use of age as a proxy for capacity, or reliance upon capacity itself as the final arbiter of entitlement to decide.

### B. Québec Civil Law

The Québec analysis of minors' access to health care decision-making blends the underlying concerns and themes of common law jurisdictions' four doctrinal approaches. Article 14 of the CCQ reads:

[Para.1] Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor.

[Para.2] A minor fourteen years of age or over, however, may give his consent alone to such care. If his state requires that he remain in a health or social services establishment for over twelve hours, the person having parental authority or tutor shall be informed of that fact.

At first glance, the rule contained in Article 14, para.2 appears absolute: a minor under the age of 14 may not make treatment decisions, but a minor who is at least 14 years old may make her own health care decisions. It would be misleading, however, to simply declare that “quatorze

ans est l'âge de majorité en matière médicale."<sup>65</sup> The precise civil law rule depends on both the nature of the treatment being contemplated and the consequences associated therewith.

### 1. Minors Younger than 14 Years of Age

The only certainties in the Québec regime relate to minors younger than 14 years old. A younger minor lacks the authority to either consent to or refuse treatment; Articles 12 and 33 grant this decision-making authority to her parents.<sup>66</sup> Under Art.16 of the CCQ, the court may also determine whether a younger minor receives treatment (if the court disagrees with the parents' refusal).<sup>67</sup> If it is impractical to apply to the court, the Director of Child Welfare may, if she disagrees with the parents' refusal, authorise physicians to administer the recommended treatment under Arts. 46 and 47 of the *Youth Protection Act*.<sup>68</sup>

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<sup>65</sup> P.-A. Crépeau, "Le Consentement du Mineur en Matière de Soins et Traitements Médicaux ou Chirurgicaux Selon le Droit Civil Canadian" (1974) 52 R. du B. can. 247 at 254.

<sup>66</sup> Articles 12 and 33 dictate the standard for decision-making on behalf of a minor. Article 12 of the CCQ reads:

[Para.1] A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, taking into account, as far as possible, any wishes the latter may have expressed.

[Para.2] If he gives his consent, he shall ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the circumstances and that the risks incurred are not disproportionate to the anticipated benefit.

Article 33 of the CCQ reads:

[Para.1] Every decision concerning a child shall be taken in light of the child's interests and the respect of his rights.

[Para.2] Consideration is given, in addition to the moral, intellectual, emotional and physical needs of the child, to the child's age, health, personality and family environment, and to the other aspects of his situation.

<sup>67</sup> Article 16 of the CCQ reads:

[Para.1] The authorization of the court is necessary where the person who may give consent to care required by the state of health of a minor or a person of full age who is incapable of giving his consent is prevented from doing so or, without justification, refuses to do so; it is also required where a person of full age who is incapable of giving his consent categorically refuses to receive care, except in the case of hygienic care or emergency.

[Para.2] The authorization of the court is necessary, furthermore, to cause a minor fourteen years of age or over to undergo care he refuses, except in the case of emergency if his life is in danger or his integrity threatened, in which case the consent of the person having parental authority or the tutor is sufficient.

<sup>68</sup> *Youth Protection Act*, R.S.Q., c.P-34.1 (QL), Arts.46, 47 [*Youth Protection Act*]. Article 46 of the Act reads: The director may apply the following, as urgent measures:

...

(b) entrusting the child to an institution operating a rehabilitation centre or a hospital centre, to a foster family to an appropriate body or to any other person without delay.

Article 47 of the Act reads:

[Para.1] The child must be consulted about the application of urgent measures; his parents must also be consulted whenever possible.

## 2. Minors Aged 14 Years and Older

**Consent:** Article 14, para.2 of the *CCQ* provides that consent given by minors aged 14 or older to medical treatment necessitated by the state of their health – therapeutic health care – may be treated as valid. Article 17 of the *CCQ* entitles a minor aged 14 or older to consent to non-therapeutic medical treatment *unless* there are serious risks attached and the treatment may result in grave and permanent effects;<sup>69</sup> if these risks and possible consequences are present, parental consent is necessary.

**Refusal:** A minor aged 14 or older is not necessarily entitled to refuse medical treatment. Deleury and Goubau note that “le droit du mineur de 14 ans et plus de refuser des soins requis par son état de santé s’analyse aujourd’hui comme un droit relatif.”<sup>70</sup> Speaking for the Court of Québec in *Protection de la Jeunesse – 599*,<sup>71</sup> Justice Tremblay concluded that, while a 14-year-old minor can consent to treatment required by the state of her health, her refusal of necessary treatment holds uncertain value. On one hand, Justice Tremblay supported commentators’ suggestions that parental or court authorisation of treatment is sufficient to override the refusal of minors who are 14 years old and older.<sup>72</sup> On the other hand, Justice Tremblay questioned whether imposing treatment in these circumstances would survive scrutiny under Art.1 of the

[Para.2] Where the parents or the child object to the application of urgent measures, the director may compel their consent. However, the director must submit the case to the tribunal with the least possible delay.

If it is an emergency, or if the minor’s parents are unavailable to consent, treatment can be administered in the absence of consent under Art.13 *CCQ*.

<sup>69</sup> Article 17 of the *CCQ* reads:

A minor fourteen years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor and may cause him grave and permanent effects.

In certain circumstances, Article 24, para.1 of the *CCQ* requires that this consent be made in writing:

Consent to care not required by a person’s state of health, to the alienation of a part of a person’s body, or to an experiment shall be given in writing.

<sup>70</sup> Edith Deleury and Dominique Goubau, *Le Droit des Personnes Physiques*, 3rd ed. (Cowansville: Les Éditions Yvon Blais, 2002) at para.103.

<sup>71</sup> [1993] R.J.Q. 611 (C.Q. jeun.) at 614-15.

<sup>72</sup> Where the treatment under consideration is not required by the state of the minor’s health, however, only the court can authorise the treatment to proceed. Consent given by a minor’s parents is of no effect in this situation. See e.g. *Allan Memorial Institute v. McIntosh* (1999), REJB 1999-15815.

*Charter* and Arts.19 and 19.1 of the former *Civil Code of Lower Canada*.<sup>73</sup> Since Justice Tremblay concluded that the 17-year-old adolescent before the court was incapable of consenting to or refusing treatment, Justice Tremblay did not need to answer this difficult question.

In contrast, speaking in the more recent Québec Court of Appeal case of *J.M.W. c. S.C.W.*,<sup>74</sup> Justice Baudouin tentatively affirmed, *obiter*, the right of the 14-year-old minor to refuse therapeutic medical treatment:

Toutefois, l'exercice de ce droit de refus présuppose l'aptitude mentale d'en décider c'est-à-dire, d'une part, la conscience de la nécessité de l'administration des soins et, d'autre part, la réalisation des conséquences du refus. Ainsi, le témoin de Jéhovah conscient que son état nécessite une transfusion sanguine et sachant que son absence entraînera sa mort, peut la refuser pour des motifs religieux. Par contre, un mineur de moins de 14 ans ou la personne inapte appartenant à la même religion et qui n'ont donc pas cette conscience peuvent être traités.<sup>75</sup>

As Nouri and Philips-Nootens contend, Justice Baudouin thereby seems to suggest that a minor who is at least 14 years of age is granted unrestricted decision-making authority in respect of any recommended health care.<sup>76</sup> Justice Baudouin's views are, however, in the minority on this issue. While there is still room for debate, it is difficult to support Justice Baudouin's views because, if a minor over 14 could by herself refuse treatment, Art.14, para.1 of the *CCQ* would be of no effect whatsoever. On its face, para.1 plainly entitles doctors to act on parental consent alone.

A more difficult issue, perhaps, is whether medically necessary treatment refused by a minor who is at least 14 years old can be upheld if her parents support her refusal and decline to consent under Art.14, para.1. There is no consensus on this question. Knoppers and Le Bris suggest that "[s]i les parents respectent la décision du mineur et refusent également les soins,

<sup>73</sup> No longer in force. Similar provisions may now be found in Arts.3, 10, 11 *CCQ*.

<sup>74</sup> [1996] A.Q. 65 (C.A.) [*J.M.W.*].

<sup>75</sup> *Ibid.*, Baudouin J. at para.39.

<sup>76</sup> Robert Kouri and Suzanne Philips-Nootens, *Le Corps Humain, L'Inviolabilité de la Personne et le Consentement aux Soins* (Sherbrooke, Qc.: Les Éditions Revue de Droit, 1999) at 411, note 934 [Kouri and Philips-Nootens, *Le Corps Humain*].

le médecin doit respecter ce double refus.”<sup>77</sup> But the weight of legislative provisions and commentary is against them. Kouri and Philips-Nootens maintain that treatment can be imposed despite both refusals, on the basis that a minor who is at least 14 years of age is still not as capable a decision-maker as an adult.<sup>78</sup>

There may be circumstances in which physicians accept a minor’s and her parents’ refusals, especially if the prognosis for successful intervention is poor. But if the Director of Child Welfare believes that treatment should proceed despite the double rejection, Arts.46 and 47 of the *Youth Protection Act* entitle the Director to authorise the treatment to proceed without seeking court authorisation.<sup>79</sup> Further, the court may authorise the imposition of treatment under Art.16, para.2 of the *CCQ*.<sup>80</sup> In making its decision, Art.23 of the *CCQ* obliges the court to take into account the adolescent’s views, and to respect her refusal unless treatment is necessitated by the state of her health.<sup>81</sup>

The Québec Superior Court case of *Protection de la Jeunesse – 884*<sup>82</sup> provides an example of the court overriding the opinions of both a minor who is at least 14 years old and her parents. In this case, a 14-year-old suffering from scoliosis of the spinal column, refused to undergo a necessary operation. She and her parents were members of the evangelical church. The adolescent believed that she would be cured by prayer, and her parents supported her

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<sup>77</sup> B. Knoppers and S. Le Bris, “L’inviolabilité de la personne et responsabilité hospitalière à la lumière de nouveau Code civil du Québec: Quand le prisme législative sclérose la pratique médicale” in *La Responsabilité Hospitalière, Maximiser La Protection, Minimiser L’Exposition* (Toronto: L’Institut Canadien, 1994) 1 at 33.

<sup>78</sup> Kouri and Philips-Nootens, *Le Corps Humain* at 419, para.405. See also Monique Ouellette, “Livre Premier: Des Personnes” in *La Reforme du Code Civil*, vol. 1 (Saint-Foy, Québec: Presses de l’Université Laval, 1993) at 30, para.45.

<sup>79</sup> *Supra* note 68.

<sup>80</sup> *Supra* note 67.

<sup>81</sup> Article 23 of the *CCQ* reads:

[Para.1] When the court is called upon to rule on an application for authorization with respect to care or the alienation of a body part, it obtains the opinions of experts, of the person having parental authority, of the mandatary, of the tutor or the curator and of the tutorship council; it may also obtain the opinion of any person who shows a special interest in the person concerned by the application.

[Para.2] The court is also bound to obtain the opinion of the person concerned unless that is impossible, and to respect his refusal unless the care is required by his state of health.

<sup>82</sup> [1998] R.J.Q. 816 (C.S.).

decision, though the Court doubted that they – particularly her mother – shared their daughter's beliefs that she would be cured by holy intervention.<sup>83</sup>

Speaking for the Québec Superior Court, Justice Crépeau characterised the adolescent's decision as unreasonable; the 14-year-old, he argued, lacked the capacity to separate out reality from direct intervention by God in her future. Justice Crépeau distinguished between believing that God is able to perform miracles and believing that God will perform a miracle in one's own case.<sup>84</sup> In other words, it is not the adolescent's religious beliefs that undermined her decision-making capacity, but her application of those beliefs to her own situation. In this sense, overriding the 14-year-old's refusal cannot be understood as a criticism of particular religious beliefs; it would be hard to otherwise interpret a judicial decision, however, if it concerned a faith in which a central tenet is that faith in God can cure illness.

In overriding the parents' decision to support their daughter's refusal, Justice Crépeau argued that the Court was making a difficult situation easier for them because he believed that the minor's parents did not wholeheartedly share their daughter's views, but wished to support her in her decisions.<sup>85</sup> Whether Justice Crépeau's opinion accurately interprets the parents' position is unclear on the available evidence. This discussion does make clear, however, that an older minor does *not* have the right to refuse treatment for which certain commentators and judges contend. Parental support can determine whether an older minor's treatment decision is upheld.

### 3. Comparative Analysis

Québec civil law and various common law frameworks seem to present very different approaches to determining the extent to which minors are entitled to participate in and make

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<sup>83</sup> *Ibid.*, Crépeau J. at 832.

<sup>84</sup> *Ibid.*, Crépeau J. at 831.

<sup>85</sup> *Ibid.*, Crépeau J. at 832.

their own treatment decisions. Yet, in their application, these different approaches yield similar results in some important respects.

In neither Canadian common law nor civil law jurisdictions does a minor below the age of majority possess a right to refuse therapeutic – especially potentially life-saving – medical treatment. Québec civil law is very clear on this point, as the above discussion of Art.16, para.2 and Art.23 demonstrates. Common law jurisdictions are less definitive. Even in jurisdictions that hold that minors are entitled decision-makers under the common law “mature minor” rule or consent legislation, the possibility exists that a minor’s decision may be overridden by either judicial exercise of *parens patriae*, or through the application of child welfare provisions.

As a result, the apparently lower age of entitlement to decision-maker status embodied in Art.14 of the CCQ does not appear to significantly advantage minors who wish to refuse treatment. The minors who benefit most from this provision are those who wish to conceal their treatment from their parents.<sup>86</sup> This result is not surprising if we consider the Québec legislature’s purpose in enacting its age-based rule. A review of the parliamentary debates surrounding the statutes that formed the basis of the CCQ rules reveals that age 14 was chosen as a matter of political compromise, rather than as the result of a firm belief in younger adolescents’ maturity. These precursive provisions were intended to “rassurer les administrateurs qui craignent, dans les faits, que la situation ne soit pas suffisamment claire”<sup>87</sup> while at the same time reassuring parents that the legislature was not significantly weakening their authority over their children.<sup>88</sup>

Indeed, the Québec position may actually provide less decision-making autonomy to minors than other provinces. Most common law provinces would entitle a minor to consent to therapeutic, non-urgent medical treatment either on the basis of presumed capacity or actual

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<sup>86</sup> The question of whether a minor has the right that her parents not be informed of the minor’s medical consultations, treatments and procedures is related, but not identical to the issue of entitlement to make treatment decisions. Unfortunately the complexity of the issues surrounding the right that parents not be informed of health care interventions requires that it lie outside the scope of my paper.

<sup>87</sup> *Journal des débats*, vol. 12, no. 74, mardi le 21 novembre 1972, at para.2640.

<sup>88</sup> See Kouri and Philips-Nootens, *Le Corps Humain*, *supra* note 76 at 393–96.

capacity demonstrated under application of the common law “mature minor” doctrine. In Québec a minor must attain age 14 before she is entitled to make *any* treatment decisions. A Québec minor must also defer to her parents’ wishes for most straightforward medical procedures, and does not acquire decision-making rights in the graduated manner that minors in most other provinces do.

The various provisions of the CCQ discussed above can be mapped against health care and consent legislation, the “mature minor” doctrine, child welfare legislation, and the court’s inherent *parens patriae* jurisdiction found in common law jurisdictions. The correspondence with both health care and consent, and child welfare legislation is quite clear. The underlying concerns over the current ambit of the common law “mature minor” doctrine are also apparent in Québec law. Judges interpret Art.14, para.2 of the CCQ as granting minors aged 14 or older the entitlement to consent to treatment only. This interpretation of the scope of older minors’ decision-making authority is comparable to the narrow reading of the “mature minor” doctrine that has been adopted by some common law courts. That adolescents’ refusals may be overridden by the Director of Child Welfare corresponds with the view taken in certain common law jurisdictions such as Alberta, that child welfare reforms supplant any broad interpretation of the “mature minor” rule.

The court’s entitlement to override adolescents’ refusals of medically-necessary treatment under Art.16, para.2 and Art.23 of the CCQ reflects the concern embodied in the common law *parens patriae* doctrine. While the court’s inherent jurisdiction has acquired no greater status than *dicta* in common law jurisdictions, its civil law parallel forms the basis of various decisions to override adolescent refusals of treatment. The Québec courts and legislature thereby accept the validity of a proposition that denies minors’ entitlement to make treatment decisions to a greater extent than it is clear any provinces, other than Alberta, agree is legitimate.

This comparison between the various approaches adopted in common law jurisdictions and in Québec law demonstrates that provincial jurisdictions tend to gravitate toward the age of majority as the minimum age for unrestrained entitlement to make health care decisions. In working toward this result over time, courts and legislatures act in what they perceive to be the “best interests” of the minors who come before health care providers and the courts.

## PART THREE: A SITUATION-SPECIFIC INTERPRETATION OF JUDICIAL REASONING

In this part I explore the factors that influence the decisions judges reach in particular court disputes over entitlement to make treatment decisions. I begin by contrasting the leading cases of *Walker*<sup>89</sup> and *McGonigle*,<sup>90</sup> in which adolescents sought to refuse potentially and most likely life-saving medical treatment, respectively.<sup>91</sup> I argue that the outcome in an individual case does not, strictly speaking, depend upon the interpretation and application of the confusing and uncertain available legal doctrines. Rather, the judge's decision is determined by a combination of the likelihood that the proposed treatment will be successful and the invasiveness of the procedure, which determine whether a minor's refusal will be upheld or overridden.

### I. ***REGION 2 HOSPITAL CORP. v. WALKER: UPHOLDING A MINOR'S REFUSAL***

Fifteen-year-old Joshua Walker was diagnosed with acute myeloid leukaemia, and because of his religious beliefs as a Jehovah's Witness, he sought to refuse blood transfusions, which, combined with chemotherapy, were part of the recommended treatment. The minor's physicians felt that he "was sufficiently mature to understand the consequences of his refusal to have transfusions."<sup>92</sup> His physicians also testified that they would not be prepared to administer

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<sup>89</sup> *Walker*, *supra* note 7.

<sup>90</sup> *McGonigle*, *supra* note 8.

<sup>91</sup> There are several reasons why I have chosen to focus on two decisions concerned with minors who refuse *critical* health care. First, the issue of forcible administration of critical medical care is much more frequently before the courts than is the issue of the imposition of (merely) beneficial medical treatment. Most of these cases are resolved through co-operation between the minors, their parents, health care providers and, sometimes, child welfare authorities without the need for legal intervention. Second, the high stakes of the decision before the court in critical health care cases tests judges' commitment to particular principles such as the "mature minor" doctrine, and thus provides greater insight into the underlying basis of judicial reasoning in medical treatment cases than would analysis of cases in which the administration of beneficial treatment was at stake. Third, the frequency with which matters of potentially life-saving medical treatment are dealt with by the courts, and the significance of the case's consequences means that it is through this type of case that judges shape and develop the law.

<sup>92</sup> *Walker* (N.B.C.A.), *supra* note 7, Hoyt C.J.N.B. at para.4.

any transfusions to the minor themselves, if the court authorised those transfusions. The 15-year-old consented to an alternative course of treatment, which did not include transfusions. The hospital and the hospital physician accepted the validity of the minor's refusal of treatment, and petitioned the New Brunswick Court of Queen's Bench for a declaration that the adolescent was a mature minor capable of refusing the transfusions.

In the Court of Queen's Bench, Justice Turnbull refused to declare the adolescent a minor entitled to make his own treatment decisions, and held that if the minor was likely to die without the transfusions, they should be administered to him.<sup>93</sup> This decision was reversed by the New Brunswick Court of Appeal, which declared the adolescent to be a mature minor within the terms of the *Medical Consent of Minors Act*,<sup>94</sup> and thereby entitled to decide the course of his future treatment.<sup>95</sup> Though the five judges presiding in the Court of Appeal agreed on the result, they disagreed on the broader issue of minors' entitlement to refuse critical health care.

Chief Justice Hoyt (with whom Justices Ayles and Turnbull agreed) contended that statutory mature minors are entitled to refuse as well as consent to treatment.<sup>96</sup> Chief Justice Hoyt further argued that the doctors' assessment of the issues was determinative: it is for the treating physicians to decide whether the proposed treatment (or non-treatment) is in the best interests of the minor and his continuing health and well-being, and whether the minor is sufficiently mature; there is no need for a court order.<sup>97</sup> Chief Justice Hoyt similarly contended that, once a minor has been held mature, there is no room for the operation of the *parens patriae* jurisdiction.<sup>98</sup>

Justice Angers disputed the suggestion that a medical assessment should control the outcome; he argued that the questions were legal in nature and should be answered in court.<sup>99</sup>

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<sup>93</sup> *Walker* (N.B.Q.B.), *supra* note 7, Turnbull J. at para.8.

<sup>94</sup> *Medical Consent of Minors Act*, *supra* note 19.

<sup>95</sup> *Walker* (N.B.C.A.), *supra* note 7, Hoyt C.J.N.B. at para.20.

<sup>96</sup> *Ibid.*, Hoyt C.J.N.B. at para.23.

<sup>97</sup> *Ibid.*, Hoyt C.J.N.B. at para.32.

<sup>98</sup> *Ibid.*, Hoyt C.J.N.B. at para.29.

<sup>99</sup> *Ibid.*, Angers J.A. at para.38.

Justice Angers also doubted that the *Medical Consent of Minors Act* supersedes the inherent jurisdiction.<sup>100</sup> But because of the adolescent's maturity, he agreed with the result reached by Chief Justice Hoyt.<sup>101</sup> Justice Ryan doubted that the *Act* was intended to entitle mature minors to both consent to and refuse treatment,<sup>102</sup> especially where refusal does not produce "at least, a positive result" for the minor.<sup>103</sup> Justices Ryan and Angers agreed that a role for the court's *parens patriae* jurisdiction persists despite the *Act* and the adolescent's maturity.<sup>104</sup>

The basis of the Court of Appeal's decision is difficult to discern from the individual speeches. All agreed on the adolescent's maturity, yet that cannot be the basis of the decision since both Justices Angers and Ryan were prepared to override a mature adolescent's decision through exercise of the court's inherent jurisdiction. Yet, it is significant that Justices Angers and Ryan did not advocate the exercise of *parens patriae* in *Walker*. While not evident in the reasoning, the outcome was likely based on the prognosis for the chemotherapy and blood transfusions.<sup>105</sup> A poor prognosis, his doctors' belief that forced treatment would aggravate the minor's condition, and their refusal to administer transfusions if any were ordered, strongly suggested that authorising blood transfusions would harm the adolescent. Joshua Walker died at home five and-a-half months later.

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<sup>100</sup> *Ibid.*, Angers J.A. at para.40.

<sup>101</sup> *Ibid.*, Angers J.A. at para.43.

<sup>102</sup> *Ibid.*, Ryan J.A. at paras.52, 57-58.

<sup>103</sup> *Ibid.*, Ryan J.A. at para.53.

<sup>104</sup> *Ibid.*, Ryan J.A. at para.70.

<sup>105</sup> This argument is supported by more explicit reference to prognosis in the two other cases in which a minor's refusal has been upheld. See *L.D.K.*, *supra* note 32, and *Re. A. Y.*, [1993] N.J. No. 197 (Nfld. S.C.) [A. Y.]. *A. Y.* is discussed in section III, below.

## II. ***C.U. (NEXT FRIEND OF) v. McGONIGLE:*** **OVERRIDING A MATURE ADOLESCENT'S** **REFUSAL**

When Candice Unland<sup>106</sup> was 16 and-a-half years old, she had been a member of the Jehovah's Witness faith for nine months, and had held firm religious beliefs prior to that point. She was an intelligent grade 11 student who enjoyed school and volunteering. However, one month she suffered from excessive menstrual bleeding and, after unsuccessful treatment with birth control and iron pills, she was admitted to a hospital emergency department in Edmonton. The physician treating the minor thought that she required an examination under anaesthesia, dilation and curettage and, possibly, a hysterectomy. The adolescent consented to these procedures, but refused any blood transfusion that might become necessary in the course of the operation on the basis of both her religious beliefs, and her fear of contracting a disease from the transfusion. She carried an Advance Medical Directive card, which also stated this refusal. The physician told her that she could die without a blood transfusion (transfusions are needed in about 20 percent of cases involving the three procedures named above).

The minor's parents fully supported her decision. Unable to secure her consent, the hospital notified Family and Social Services, who then sought a Treatment Order from the Alberta Provincial Court.<sup>107</sup> Judge L.S. Witten granted a Treatment Order, which included the administration of blood transfusions, but he provided no reasons for his decision. A blood transfusion was later administered when complications resulted from post-treatment care. Unlike many other adolescents with whom this case-law is concerned, Candice Unland recovered from her illness.

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<sup>106</sup> *McGonigle*, *supra* note 8.

<sup>107</sup> The Treatment Order was requested under ss.17(1), 20(5) of the 1984 *Child Welfare Act*, which is currently in force as *Child Welfare Act 2000*, *supra* note 42.

The adolescent appealed to the Alberta Court of Queen’s Bench, arguing that she was a “mature minor” at common law who should have been entitled to refuse treatment.<sup>108</sup> The Alberta *Child Welfare Act*,<sup>109</sup> she contended, did not apply to “mature minors.” Justice Clarke agreed that the adolescent satisfied the requirements for “mature minor” status. He considered her maturity – which Judge Witten had disregarded – but concluded that maturity was not the critical issue. Justice Clarke affirmed the order made below on the basis that the *Child Welfare Act* superseded the common law doctrine, and was “a complete and exclusive code for dealing with this issue.”<sup>110</sup> Justice Clarke denied the adolescent’s *Charter* claims without offering any detailed explanation.<sup>111</sup>

Justice Clarke’s decision was upheld on the minor’s appeal to the Alberta Court of Appeal. Justice Russell dismissed the adolescent’s *Charter* arguments: since the minor had indicated in the court below that she would not dispute the validity of the *Child Welfare Act*, only how it applied to her, she could not do so now.<sup>112</sup> Justice Russell stated that Justice Clarke had implicitly declared the adolescent to be a “mature minor.”<sup>113</sup> Yet, as Justice Clarke had ruled in the court below, this did not assist the minor because Justice Russell reaffirmed that the “mature minor” doctrine does not apply in the context of the *Child Welfare Act*.<sup>114</sup> By way of explanation, Justice Russell contrasted the position of the *parens patriae* jurisdiction to that of legislative enactments vis-à-vis the common law doctrine:

While a court may be unable to exercise its *parens patriae* jurisdiction with respect to a mature minor who is no longer in need of protection from the court, the provincial

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<sup>108</sup> Since a transfusion had been administered, the purpose of Candice Unland’s appeal was to have the orders declared a nullity and, no doubt, to improve the position for those adolescents who might find themselves in a similar situation in the future.

<sup>109</sup> *Child Welfare Act*, *supra* note 42.

<sup>110</sup> *McGonigle* (Alta. Q.B.), *supra* note 8, Clarke J. at para.22.

<sup>111</sup> *Ibid.*, Clarke J. at para.28. Justice Clarke relied on Justice Perras’ decision in *Harrison*, a decision which neither dealt with the s.15(1) issue, nor addressed a similar factual situation to *McGonigle*. The minor in *Harrison* was three years old and in need of a cardiac bypass in order to have a chance at life; the adolescent in *McGonigle*, however, was sufficiently mature to make her own treatment decisions, and there was only a 20 percent chance of her needing a blood transfusion. See *Alberta (Director of Child Welfare) v. Harrison*, [1996] A.J. No. 501 (Alta.Q.B.) [*Harrison*].

<sup>112</sup> *McGonigle* (Alta. C.A.), *supra* note 8, Russell J.A. at para.14.

<sup>113</sup> *Ibid.*, Russell J.A. at para.26.

<sup>114</sup> *Ibid.*, Russell J.A. at para.37.

legislature may enact laws with respect to such a person to the same extent it may enact laws with respect to its adult subjects.”<sup>115</sup>

Justice Russell’s justification for the overarching authority of child welfare legislation is confusing because the legislature cannot restrict an adult’s entitlement to make her own treatment decisions, unless she is shown to be incapable; hence, the logic of Justice Russell’s argument seems to undermine her own conclusion, since her argument implies that, a mature minor, as the holder of equivalent legal status to an adult, should *not* have her decision-making authority restricted by statute.

Justice Russell offered three additional reasons for her decision, none of which are decisive. First, Justice Russell suggested that, because the *Child Welfare Act* states that a minor capable of expressing an opinion shall have that opinion taken into account, the legislative scheme expressly provides for the correct approach toward “mature minors” and continued application of the common law rule would be inconsistent with that Act.<sup>116</sup> But not all those minors who are able to express an opinion are also “mature minors.” As a consequence, it is not inconsistent with the Act that minors with greater maturity are entitled to make their own decisions, while minors with less maturity but who are nevertheless capable of expressing an opinion, are entitled to do so.

Second, Justice Russell contended that her decision was “consistent with society’s historic interest in preserving the life and well-being of minors.”<sup>117</sup> But this overlooks the fact that this interest was never intended to outweigh a minor’s mature treatment decision, but rather reflected the idea that the age of majority served as a proxy for sufficient decision-making maturity. Since we now understand that some minors develop that maturity, it is not inconsistent with society’s historic protection of minors that mature minors are entitled to make decisions that may result in detrimental consequences for their physical health.

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<sup>115</sup> *Ibid.*, Russell J.A. at para.33.

<sup>116</sup> *Ibid.*, Russell J.A. at para.37.

<sup>117</sup> *Ibid.*, Russell J.A. at para.38.

Third, Justice Russell argued that obliging the decision-maker to listen to the minor's opinion under the *Child Welfare Act*, without necessarily having to act on the minor's expressed views (as the "mature minor" doctrine would require), is consistent with Canada's obligations under the *United Nations Convention on the Rights of the Child*.<sup>118</sup> As I explore below, the extent of the obligations imposed by Art.12 of the *CRC* is far from clear. It may be sufficient to merely take into consideration the views of a minor "capable of forming their own views."<sup>119</sup> But, in other situations, "giv[ing] due weight" to a minor's views "in accordance with [her] age and maturity"<sup>120</sup> may be understood to require nothing less than upholding her decision.

These difficulties with Justice Clarke's and Justice Russell's reasoning suggests that they may both have interpreted the role of the *Child Welfare Act* as they did more as a means to an end – ensuring that an easily administrable transfusion helped an adolescent attain the age of majority – than as the logical conclusion of statutory interpretation. It is not unreasonable to conclude that the result in *McGonigle* may have been based on prognosis for recovery and the invasiveness of the proposed treatment. Two additional observations support this conclusion: first, it was highly likely that a minimal number of transfusions would have been sufficient to save the adolescent's life; second, unlike in many cases concerned with minors who refuse critical medical care, the treatment Candice Unland refused was not (in a physical sense, at least) highly invasive. The Supreme Court of Canada refused leave to appeal without reasons.<sup>121</sup>

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<sup>118</sup> *Ibid.* See *United Nations Convention on the Rights of the Child*, 20 November 1989, 1577 U.N.T.S. 3 [*CRC*].

<sup>119</sup> *CRC*, Art.12.

<sup>120</sup> *Ibid.*

<sup>121</sup> *McGonigle* (S.C.C.), *supra* note 8.

### III. ANALYSIS

On the role of prognosis and invasiveness in judicial reasoning more generally, Sneiderman observes:

[A] favourable prognosis and limited invasiveness might lead [the judge] to rule that the minor lacks the maturity to decide for herself. And a less sanguine prognosis coupled with a high degree of invasiveness might lead her to the opposite conclusion. (In either case, the judge might not even be consciously aware of the “extralegal” factors that have influenced her decision).<sup>122</sup>

And in the passage immediately preceding these comments, Sneiderman remarks that “on the issue of decisional capacity a case falling in the grey zone [between immaturity and maturity] might go either way, depending on such factors as the invasiveness of the procedure and the prognosis itself.”<sup>123</sup>

The facts and the decision and reasoning of the New Brunswick Court of Appeal support this interpretation of *Walker*. Two other leading cases in which the courts upheld minors’ refusals of critical health care also support Sneiderman’s thesis. In *L.D.K.*,<sup>124</sup> a 12-year-old minor suffering from acute myeloid leukaemia refused chemotherapy and the necessary accompanying blood transfusions. The minor’s decision was founded upon both her beliefs as a Jehovah’s Witness and her desire not to experience the pain and suffering that treatment would entail.

Speaking for the Ontario Provincial Court, Judge Main concluded that the minor was not a child “in need of protection” under Ontario child welfare legislation,<sup>125</sup> and held that she was entitled to refuse treatment. Judge Main relied on the minor’s maturity as the basis for dismissing the application for authorising imposed medical treatment. Yet, if the minor’s

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<sup>122</sup> Sneiderman, *supra* note 6 at 479.

<sup>123</sup> *Ibid.*

<sup>124</sup> *L.D.K.*, *supra* note 32.

<sup>125</sup> *Child Welfare Act*, R.S.O. 1980, c. 66, s.19(ix); now in force as *Child and Family Services Act*, *supra* note 55, s.37(2)(e).

maturity was in fact at the core of his decision, why did Judge Main contend that she was entitled to be consulted only, rather than entitled to decide?

Further, the conclusion reached was, as a technical matter of law, that the minor was not a child “in need of protection” because her parents had not refused “proper” medical treatment. The notion of “proper” care depends on both prognosis and invasiveness. Indeed, Judge Main stressed several relevant factors in his decision: the poor prognosis for treatment, which was believed to be no better the prognosis for the family’s proposed alternative;<sup>126</sup> the fact that the recommended procedure would only treat the minor in a physical sense, and not also address her emotional needs and religious beliefs;<sup>127</sup> and the extensive nature – the invasiveness – of the proposed treatment and its side-effects.

In the Newfoundland case of *A. Y.*,<sup>128</sup> a 15-year-old member of the Jehovah’s Witness faith was diagnosed with acute myeloid leukaemia. He refused chemotherapy and accompanying transfusions. Prognosis was very poor; the minor’s treating physician put the prognosis for arrest of the disease at between 10 and 40 percent, and stressed that this was not even the prognosis for complete recovery and cure.<sup>129</sup> Justice Wells held that the minor was entitled to refuse treatment on the basis that he was “mature” enough to have his wishes respected.<sup>130</sup> Yet, analysis of his decision suggests that the stated basis of maturity was not in fact the prime motivation for Justice Wells to reach that decision; if maturity was what was important, there would have been no need for Justice Wells’ emphasis on poor prognosis for survival or recovery in his reasoning.<sup>131</sup>

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<sup>126</sup> This is debatable since the family’s proposed alternative – mega-vitamin treatment – had a proven success rate of 0 percent, compared with the 30 percent success rate for chemotherapy accompanied by blood transfusions. Sneiderman notes that that 30 percent figure had risen to around 50 percent by 2000. See Sneiderman, *supra* note 6 at 464.

<sup>127</sup> *L.D.K.*, *supra* note 32, Main Prov.Ct.J. at para.21.

<sup>128</sup> *A. Y.*, *supra* note 105.

<sup>129</sup> *Ibid.*, Wells J. at para.14.

<sup>130</sup> *Ibid.*, Wells J. at para.34.

<sup>131</sup> Justice Wells stated: “... I am not satisfied that in this particular case the use of blood products as a follow-up to chemotherapy is considered essential by the qualified medical practitioner from whom I have heard and in whom I have considerable confidence.” See *ibid.*, Wells J. at para.29.

The result in *McGonigle* suggests that judicial reliance on invasiveness and prognosis may extend beyond cases in which the minor's maturity is not clear.<sup>132</sup> The 16 and-a-half-year-old adolescent in *McGonigle* was clearly mature and acknowledged as such by Alberta courts; treatment was authorised *despite* her maturity. As a result, prognosis and, to a lesser extent, the nature of the treatment under consideration, may underpin judicial reasoning even when it is clear that the adolescent is sufficiently "mature" to make her own decisions.

Another leading Alberta case, *B.H.*, supports my analysis of the result in *McGonigle*. In *B.H.*,<sup>133</sup> a 16-year-old Jehovah's Witness was suffering from acute myeloid leukaemia. She refused blood transfusions, which were a necessary part of her treatment in addition to chemotherapy. At the time of her refusal, the proposed transfusions and chemotherapy were life-extending, rather than life-saving:<sup>134</sup> doctors assessed prognosis at between 40 and 50 percent with the chemotherapy, with the possibility that this would enable a bone marrow transplant, which would in turn increase prognosis to between 50 and 65 percent. Judge Jordan, speaking for the Alberta Provincial Court, authorised the forcible administration of blood transfusions. Judge Jordan held that the adolescent was not a "mature minor" because she neither understood on an experiential level what it was to die,<sup>135</sup> nor had she questioned her religious beliefs.<sup>136</sup>

Justice Kent, in the Alberta Court of Queen's Bench, criticised Judge Jordan's interpretation of the "mature minor" doctrine: religious beliefs could not by themselves prevent an individual from becoming a "mature minor."<sup>137</sup> But Justice Kent believed the adolescent had been a "mature minor," Justice Kent understood the minor to have lost her mature capabilities

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<sup>132</sup> See Sneiderman, *supra* note 6 at 479.

<sup>133</sup> *B.H.*, *supra* note 2. Though *McGonigle* was commenced prior to *B.H.* (hence in *B.H.* (Alta.Q.B.) Justice Kent endorsed the views of Justice Clarke in *McGonigle* (Alta.Q.B.), *B.H.* reached its highest level of appeal prior to *McGonigle*. In this sense, each case had the potential to inform judicial reasoning in the other case.

<sup>134</sup> For an explanation of the distinction between these different prognosis-based concepts, see Sneiderman, *supra* note 6 at 420. The sliding scale of prognosis moves from potentially life-saving, to life-extending, to likely life-saving medical treatment.

<sup>135</sup> *B.H.* (Alta. Prov. Ct.), *supra* note 2, Jordan Prov. Ct. J. at para.22.

<sup>136</sup> *Ibid.*, Jordan Prov. Ct. J. at para.24-25.

<sup>137</sup> *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at para.36.

as the case wore on. Justice Kent contended that the adolescent had been unduly influenced in her decision by her mother and members of her church. In this regard, Justice Kent criticised the minor's mother for her behaviour in the hospital and for likening her daughter's medical treatment to the sufferings of victims of Nazi torture.<sup>138</sup> Justice Kent noted that the minor told a nurse that she would not die if she did not receive a transfusion, which, Justice Kent suggested, indicated that the minor did not (at least, not at that point in the proceedings) truly comprehend that the consequences of her refusal included certain death.<sup>139</sup>

Justice Kent based her decision on the application of the *Child Welfare Act*, but she also indicated that she would have adopted the same reasoning were the adolescent still "mature" at the time of her decision. Because Justice Kent considered it in the adolescent's "best interests" that she receive treatment, she would have authorised treatment regardless of the adolescent's maturity. Justice Kent's reasoning thus centred on prognosis, rather than maturity, although the minor had in fact become immature by the time of the hearing in the Court of Queen's Bench.

The emphasis placed on physical well-being is understandable to the extent that it more easily fits with the principles embodied within child welfare legislation than a more holistic approach. Determining the effect of a particular treatment on an individual's holistic well-being would entail doctors and a court looking at the impact of treatment on an individual's physical, mental, emotional and spiritual health. Consideration of physical health presents the issues to judges in a more manageable way than the potentially huge volume of conflicting views that might surround investigation into matters such as the importance of religious beliefs to minors, or the enduring effects of emotional trauma.<sup>140</sup>

In cases in which prognosis for physical recovery is reasonable or good, there is a noticeable lack of weight placed on the spiritual aspects of prognosis. Conversely, in cases

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<sup>138</sup> *Ibid.*, Kent J. at para.67.

<sup>139</sup> *Ibid.*, Kent J. at para.73-78.

<sup>140</sup> Joan M. Gilmour, "Children, Adolescents, and Health Care" in Jocelyn Downie, Timothy Caulfield, Colleen Flood, *Canadian Health Law and Policy*, 2nd ed. (Markham, On.: Butterworths, 2002) 205 at 230.

such as *L.D.K.*, *A.Y.* and *Walker*, judges take a more holistic approach to determining prognosis. Again, this reveals judges' paternalistic approach to determining whether the forcible administration of treatment is authorised: judges stress physical prognosis alone when consideration of the minor's spiritual and emotional well-being could result in a minor not receiving treatment that has a good chance of saving the minor's life.<sup>141</sup>

These cases reveal the central difficulty in legal frameworks that govern minors who assert entitlement to make their own health care decisions – the courts and provincial legislatures have failed to directly address whether maturing adolescents are accurately categorised as “minors.” While the common law “mature minor” doctrine and various provincial consent statutes attempt to respond to adolescents' developing maturity, child welfare provisions are employed in an effort to protect *all* minors from the consequences of their own decisions. Part Four explores minors' cognitive, psychosocial and neurological development to accurately determine the extent to which this emphasis on protection fails to reflect the reality of minors' decision-making maturity.

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<sup>141</sup> These factors are more likely to be taken into account, therefore, if the recommended treatment is not urgent. In *Chmiliar*, the Alberta Court of Queen's Bench did not override a 13 year-old's irrational fear of vaccinations (instilled by her mother) to administer a vaccination because there was no serious health risk, and it was hoped that the minor would soon develop into a mature decision-maker. See Gilmour, *ibid.* at 232. *Chmiliar v. Chmiliar*, [2001] A.J. No. 838 (Alta. Q.B.) [*Chmiliar*].

## PART FOUR: RESEARCH INTO THE NATURE OF A “MATURE” DECISION

Part Four explores the current state of psychological and neuroscientific research into minors' decision-making maturity. Through this discussion we can determine the accuracy of the argument that age (more often than not, the age of majority) acts as a shorthand for maturity. Are legislatures and the courts acting on the basis of inaccurate assumptions about maturity?<sup>142</sup>

### I. MINORS' PSYCHOLOGICAL DEVELOPMENT

#### A. Cognitive Capabilities

Much of the psychology research into minors' cognitive abilities to make complex decisions, as well as the vast majority of the legal literature that attempts to learn from this research, focuses on the development of abstract cognitive capabilities, principally those contained in Piaget's stage model.<sup>143</sup> The psychology literature is generally consistent with Piaget's contention that abstract cognitive maturity is attained by adolescence, as the minor shifts from “concrete operational” to “formal operational”<sup>144</sup> thinking from age 12 onwards. Psychology research tends to cluster around 14 years of age as the age at which the average adolescent is as competent as an adult is presumed to be in terms of formal operational or abstract reasoning.<sup>145</sup>

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<sup>142</sup> For a good introduction to the current state of research in this field, see Paul A. Klaczynski, James P. Byrnes, and Janis E. Jacobs, “Introduction to the Special Issue: The Development of Decision-Making” (2001) 22 *Applied Developmental Psychology* 225.

<sup>143</sup> Bärbel Inhelder and Jean Piaget, *The Growth of Logical Thinking from Childhood to Adolescence*, trans. by Anne Parsons, Stanley Milgram (U.S.A.: Basic Books, 1958); Jean Piaget and Bärbel Inhelder, *The Psychology of the Child* (... : Routledge & Kegan Paul, 1969).

<sup>144</sup> “Formal operational thinking” is understood as “the ability to consider abstract ideas and manipulate mental representations systematically (logically).” My thanks to Nadine Richard for this summary.

<sup>145</sup> See e.g. Lois A. Weithorn and Susan B. Campbell, “The Competency of Children and Adolescents to Make Informed Medical Treatment Decisions” (1982) 53 *Child Dev.* 1589; Catherine C. Lewis, “A Comparison of Minors' and Adults' Pregnancy Decisions” (1980) 5 *Am. J. Orthopsychiatry* 446. These two studies can be criticised for their methodology (examining performance on “hypothetical” decision-making tasks, rather than in real-life situations). However., studies that have looked at minors' decision-making capabilities in real-life scenarios also generally agree with the other studies that adolescents approximately 14 years of age and older are competent decision-makers. See

General agreement that minors are mature abstract cognitive thinkers from age 14 onwards extends to psychology research into decision-making, particularly decisions made in the health care context.<sup>146</sup>

But we cannot conclude from this discussion that a minor who is at least 14 years old should necessarily be entitled to make her own treatment decisions. Piaget's model of the development of cognitive capabilities has been increasingly criticised,<sup>147</sup> and it is now recognised to provide only a partial account of the necessary elements of mature decision-making. This observation also undermines the purely cognitive conception of the common law "mature minor" doctrine that currently prevails in Canadian law.<sup>148</sup> "Maturity" is about more than the *potential* to use a particular process of reasoning to reach a decision; the minor's decision "must also reflect a sense of independence that is grounded in emotional, psychological and social maturity."<sup>149</sup>

From this critique of Piaget's more abstract construction of decision-making maturity, the current psychological literature stresses the importance of context. Ambuel and Rappaport contend that "[c]ognitive and social capacities do not develop uniformly within individuals or across settings. The level of sophistication demonstrated by a minor solving a specific problem is thought to be influenced not only by general level of cognitive development but also by

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e.g. Bruce Ambuel and Julian Rappaport, "Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion" (1992) 16 *Law & Hum. Behav.* 129.

<sup>146</sup> Jacobs et al. argue that minors as young as 12 years of age can reason in a more thorough and systematic manner when making decisions. Further, Billick et al. suggest that these young adolescents may be competent to make health care decisions. Aside from concerns regarding the weight that should be placed on Billick et al's findings because of their rather novel, hence not yet generally validated, methodology that focussed on the decisional outcomes rather than the process of decision-making, these views do not represent the preponderance of the literature. My thanks to Nadine Richard for this critique. When dealing with an issue as important as whether minors are entitled to make potentially life-or-death decisions, it is crucial that weight be placed on only the surest empirical foundations. As a result, unless further studies support this contention in relation to 12 year-olds' abilities, it seems reasonable to rely on the firmer conclusions reached in relation to 14 year-olds. See Janis E. Jacobs, Marcia A. Bennett, and Constance Flanagan, "Decision Making in One-Parent and Two-Parent Families: Influence and Information Selection" (1993) 13:3 *Journal of Early Adolescence* 245 at 247; S.B. Billick, W. Burgert, G. Friberg, A.V. Downer, and S.M. Bruni-Solhkhah, "A Clinical Study of Competency to Consent to Treatment in Pediatrics" (2001) 29: 3 *J. Am. Acad. Psychiatry Law* 298.

<sup>147</sup> See e.g. M. Cole and R. Cole, "Adolescence and Beyond in *The Development of Children* (New York, N.Y.: Scientific American Books, 1993) at 608-622; Elizabeth S. Scott, Dickon N. Reppucci, and Jennifer L. Woolard, "Evaluating Adolescent Decision Making in Legal Contexts" (1995) 19:3 *Law and Human Behavior* 221.

<sup>148</sup> See Part Two, section II.A.2 above.

<sup>149</sup> See e.g. Sneiderman, *supra* note 6 at 470.

context-specific factors including domain relevant knowledge and experience, cognitive problem solving skills, affect during decision making, and social support.”<sup>150</sup>

The relevance of context refers to more than the effects of the factual background on a minor’s cognitive abilities (e.g. the experience of illness, the stress of the decision facing the minor). The factual context may affect her emotional competence (e.g. a minor’s ability to overcome her emotionally-driven impulses, perhaps based in her knowledge of her parents’ or her community’s perception of the “right” decision) and her social-cognitive competence (e.g. a minor’s ability to overcome external pressures in making her decision).<sup>151</sup> A minor’s values and beliefs may also inhibit her decision-making, which is an important consideration when we cannot be certain that she has really accepted those beliefs as her own.

The effects of experiencing illness and stress are two significant contextual influences on minors’ cognitive competency to make health care decisions. The common law “mature minor” doctrine, health care and consent legislation, and certain provincial child welfare statutes direct judges to assess a minor’s abstract cognitive competency. There is no similar direction for judges to consider contextual influences on cognitive abilities. Nevertheless, in assessing competency some judges do take into account an adolescent’s experience with illness and/or how stressful her situation is.<sup>152</sup>

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<sup>150</sup> Ambuel and Rappaport, *supra* note 145 at 133. See also Klaczynski et al., *supra* note 145.

<sup>151</sup> The Bioethics Committee, Canadian Paediatric Society Position Statement B04-01 also supports this perspective. The Committee argue that “[c]apacity is not age- or disease-related, now does it depend on the decision itself, but is a cognitive and emotional process of decision-making relative to the medical decision.” See Bioethics Committee, Canadian Paediatric Society, Position Statement: B04-01 “Treatment Decisions Regarding Infants, Children and Adolescents” (2004) 9:2 Paediatrics and Child Health 99 [CPS, B04-01].

<sup>152</sup> See e.g. A. Y., *supra* note 105, Wells J. at paras.32-33:

Maturity is not the same in every case, and maturity can come with circumstances ... Most adults would consider fifteen year-olds to be immature in most respects, and perhaps they are.

However, I think that what has happened to A has matured him to a degree that would be unthinkable for a 15 year-old who is not facing and living with what he is living with, and has to face and is facing. I think that his experience is as bad an experience I can conceive of, and I suspect that their faith is one of the things that is sustaining him and his family. I think that what has happened has made A mature beyond any normal expectation of maturity in a 15 year-old ... [T]he boy I spoke to this morning ... is very different from a normal 15 year-old, because of this tragic experience.

Since it is context-specific experience and knowledge that may enhance decision-making,<sup>153</sup> there is no reason to think that individuals of full legal age make better health care decisions simply by virtue of greater experience in *other* contexts.<sup>154</sup> A minor who is suffering from a *chronic* illness may experience that illness intensely and over time, so that she has more insight into what is at stake in any complex decisions that need to be made about her future treatment. Whether experience of severe *acute* illness enhances a minor's abilities to make decisions about treatment of that condition much depends on her particular circumstances; while acute illnesses are generally of short duration, they are often intensely experienced, and this intensity may do much to enhance that minor's context-specific decision-making abilities.

For ethical reasons, there has been very little research into the effects over time of experiencing chronic or severe acute illness on minors' decision-making competence. Yoos' work with children with asthma suggests that a minor's capacity for making decisions in relation to her condition increase over time as a result of living with that medical condition.<sup>155</sup> It is not clear, however, whether we can draw any analogies from the experience of asthma to leukaemia or other life-threatening conditions.

The long-term experience of illness may also detrimentally impact upon a minor's development of self-knowledge and identity, and reduce her life experience. We do not yet know whether those negative consequences are generally outweighed by or outweigh the beneficial effects of previous experience.<sup>156</sup> Similarly, we do not yet know whether any positive effects on decision-making competency that may result from living with a particular illness over

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<sup>153</sup> See e.g. Elizabeth S. Scott, "Judgment and Reasoning in Adolescent Decision-Making" (1992) 37 *Vill. L. Rev.* 1607.

<sup>154</sup> See e.g. James P. Byrnes, "The Development of Decision-Making" (2002) 31 *J. Adolescent Health (Supp.)* 208; Giora Keinan, "Decision-Making under Stress: Scanning of Alternatives under Controllable and Uncontrollable Threats" (1987) 52 *J. Pers. Soc. Psychol.* 639.

<sup>155</sup> See Hannelore Lorrie Yoos, *Knowledge Representation of a Chronic Illness: A Study of Kinds of Expertise* (1990) [unpublished, archived at University of Rochester, N.Y.].

<sup>156</sup> My thanks to Nadine Richard for this point.

time are outweighed by the negative effects of stress<sup>157</sup> and the emotional nature of the decision to be made. Individual minors or perhaps most minors of a certain age may have less developed coping skills than most adults, which would render their decision-making more susceptible to the effects of stress. If decisions are less rational as a result of stress, as well as emotional, intuitive responses, this leads to a decreased chance of identifying the (medically determined) “best” solution, especially if she needs to weigh up various complex issues with serious consequences.<sup>158</sup> But this does not necessarily entail that that minor will not reach that solution, only that it will be more difficult for them to do so; how much more difficult exactly, is not at all clear.

In addition, if Byrnes is correct that minors are more likely to make more impulsive and emotional decisions than adults, it may be that stress exacerbates this further. This is not to say that minors under stress will reach a worse decision than otherwise; yet, stressed minors are less likely to systematically determine their future course of treatment, and it is systematic decision-making that is more likely to yield better outcomes when an individual faces a life-changing decision.<sup>159</sup>

As a result, it is unclear whether minors with experience of illness should tend to be better or worse than other minors at making medical treatment decisions. We can predict that minors tend to function as well as adults in abstract cognitive terms from age 14. But we are unable to draw any general conclusions in relation to ill minors because, while we can predict trends in relation to individual elements of mature decision-making, we do not yet have a

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<sup>157</sup> While there are no studies that directly consider the impact of stress on minors’ decision-making competency, research into the effects of stress on adults’ decision-making capabilities shows that stress can cause individuals to consider fewer alternatives, and examine those alternatives in a less rational manner than if they were not stressed. See Keinan, *supra* note 154. It seems reasonable to apply these findings to the issue of stress and older minors’ decision-making at least, though the extent to which stress negatively impacts upon decision-making is likely not the same for adolescents as for adults. See Byrnes, *supra* note 154.

<sup>158</sup> Byrnes, *ibid.* at 212. Because stress is inextricably linked to the issue of coping strategies, the effects of stress may be somewhat more difficult to predict than my comments indicate. The possibility that there is a developmental lag in coping strategies has not been discounted by research, although Byrnes doubts that this result is likely. See Byrnes, *ibid.* at 212-13.

<sup>159</sup> *Ibid* at 212.

method for bringing together these trends to form an overall picture.<sup>160</sup> The inability to predict ranges of cognitive decision-making maturity for minors within certain age-groups that this analysis demonstrates, suggests that an accurate determination of decisional maturity may only be achieved by focussing on the particular capabilities that would make a minor's decision mature, and not on the age of the minor.

## **B. Psychosocial Maturity**

“Psychosocial” development refers to an individual's psychological maturation in the context of her development as a social being. This includes the growth in an individual's capacity to analyse and learn from experience; to experience and regulate her emotions; to understand herself, and not to place too much emphasis on age-specific values; and to learn from others, often through advice-seeking, while not being unduly influenced by her peers, or social setting. Psychosocial maturity is critical to the question of a minor's decision-making maturity.

Indeed, judges already take into account various aspects of psychosocial development when they assess a particular minor's level of maturity. In *B.H.*, for example, Justice Kent referred to the extent to which she believed the minor had been unduly influenced by her church and (religious) family in her decision to refuse treatment as part of the rationale for overriding the minor's decision.<sup>161</sup> Analysis of individual elements of an individual's psychosocial development may provide valuable guidance to judges in their assessment of minor's decision-making maturity.

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<sup>160</sup> It is likely that even the trends that we have noted for different aspects of mature decision-making do not apply to adolescents with psychiatric problems or severe depression, which may accompany physical conditions such as leukaemia. Psychiatric problems reduce adults' ability for reasoning and, presumably, also negatively impact minors. In the absence of direct research, however, it is unclear in what respects and to what extent this negative impact occurs. For research with adults, see Billick et al., *supra* note 146; for supporting research with adolescents who have behavioural difficulties, see E.P. Mulvey and F.L. Peebles, “Are Disturbed and Normal Adolescents Equally Competent to Make Decisions about Mental Health Treatments?” (1996) 20:3 *Law and Human Behavior* 273.

<sup>161</sup> See e.g. *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at paras.66-78.

Cauffman and Steinberg found that, as a general class of abilities, an individual's psychosocial maturity improves as a function of age between adolescence and adulthood.<sup>162</sup> Yet, the researchers also concluded that there is considerable difference in performance *within* each age group. While a particular 16-year-old is likely to be more psychosocially mature than she was at 14, therefore, she is not necessarily more psychosocially mature than any other 14-year-old.

Further, given the context-specific nature of development, an individual's psychosocial competencies will be developed to differing extents. A 15-year-old may be able to apply past experiences to improve current decisions, for example, but still be highly vulnerable to grounding her decisions on the risk of short-term negative consequences for her physical appearance, rather than on the long-term prognosis for her physical health. Weithorn and Campbell's research supports this last observation. The researchers gave minors hypothetical medical treatment decisions to make, and found that 14- and 15-year-olds' decision-making was detrimentally affected by age-specific values. Twelve and-a-half percent of those minors rejected the most (medically) "reasonable" treatment for epilepsy because of the consequences it would have for their appearance and attractiveness.<sup>163</sup>

Although a minor may be vulnerable to age-specific values, however, she may be less susceptible to excessive parental influence on her decisions. Scherer and Reppucci found that 14- and 15-year-olds generally defer to parental wishes in making medical treatment decisions. But the research also revealed that if the outcome of the decision has serious health implications (e.g. kidney donation), 14- and 15-year-olds are more likely to resist parental

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<sup>162</sup> Elizabeth Cauffman and Laurence Steinberg, "(Im)maturity of Judgment in Adolescence: Why Adolescents May Be Less Capable than Adults" (2000) 18 Behav. Sci. Law 741. See also Elizabeth Cauffman and Laurence Steinberg, "The Cognitive and Affective Influences on Adolescent Decision-Making" (1995) 68 Temp. L. Rev. 1763 [Cauffman and Steinberg, "Cognitive and Affective"].

<sup>163</sup> Weithorn and Campbell, *supra* note 145. In his review of the literature, Byrnes also finds that minors' values and goals may influence the decisions they make to a greater extent that their knowledge of the alternatives and consequences. Clearly, a minor's values and goals also include short-term, age-specific values (e.g. a minor's desire as not wanting to gain weight) that are generally considered "immature" by older individuals. See Byrnes, *supra* note 154. See also Scott, Reppucci and Woolard, *supra* note 147.

influence than otherwise. However, even in this situation, there was still significant parental influence on those minors' decisions.<sup>164</sup>

Recently, Cauffman and Steinberg suggested that there may be justification for an age-based dividing line between 16- and 17-year-old minors: minors aged 16 years or younger would not be entitled to make certain decisions, but minors aged 17 or older would.<sup>165</sup> However, Cauffman and Steinberg qualified their argument – only *if* a connection between psychosocial influences and maturity of judgment could be established, *would* this age-based dividing line be justified. While the previously-discussed research demonstrates a connection between aspects of psychosocial development and maturity of judgment, the contours of this connection are too ill-defined to form the basis of any age-based rule.

There are two general statements we can make about psychosocial maturity: first, a group of young minors is less psychosocially mature than a group of older minors; second, an individual minor's psychosocial maturity improves as she ages. But we also know that different psychosocial abilities develop at varying rates within that minor, and between that minor and other minors of her age. Add to that the uncertainty as to the level of development of each psychosocial capability that forms a necessary part of "mature" decision-making, and there seems to be no justification (at least, not as yet) for embodying in law the age-based rule Cauffman and Steinberg proposed. Instead, this discussion suggests that the best approach may be to craft a legal rule that leaves it open to an individual minor to demonstrate possession of particular key components of psychosocial maturity as part of her claim for entitlement to decide.

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<sup>164</sup> David G. Scherer and N. Dickon Reppucci, "Adolescents' Capacities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas" (1988) 12 *Law and Human Behavior* 123. Jacobs et al. looked at one-parent and two-parent families and found that the extent of parental influence varied according to family make-up. See Jacobs et al., *supra* note 146. Parenting style is also important, as Peterson and Siegal argue. A minor raised by authoritarian parents may show reduced voluntariness in decision-making than other minors. See Candida C. Peterson and Michael Siegal, "Cognitive Development and the Competence to Consent to Medical and Psychotherapeutic Treatment" in Candida C. Peterson and Michael Siegal, eds., *Children's Understanding of Biology and Health*, Cambridge Studies in Cognitive Perceptual Development (Cambridge, U.K.: Cambridge University Press, 1999) 257.

<sup>165</sup> Cauffman and Steinberg, "Cognitive and Affective," *supra* note 162.

## II. NEUROSCIENCE PERSPECTIVE ON MINORS' DEVELOPMENT

Recent neuroscience research into the growth and maturation of the brain reveals that the brain is not fully developed until an individual is approximately in her mid-twenties.<sup>166</sup> Below that age, the brain cells responsible for higher cognitive functions – grey matter – have not fully developed; the less valuable connections have not yet disappeared and the most used connections have not yet been strengthened to facilitate decision-making. But whether this has any implications for minors' decision-making capabilities is, as yet, unclear. Neuroscience researchers are cautious as to the potential ramifications of their findings,<sup>167</sup> and no direct link between the extent of the brain's grey matter and an individual's decision-making competency has yet been demonstrated. The difficulty in attempting to draw any conclusions from the current state of the field is heightened by the fact that, even when the brain is fully developed, there is significance variance between individuals' brains in the volume of grey matter.

Neuroscience research also suggests that adolescents may experience stronger emotional reactions to simple reasoning tasks than adults.<sup>168</sup> But, as with psychological research into the role of emotional responses in decision-making, it is not clear that heightened emotional responses necessarily impair decision-making competency.

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<sup>166</sup> See e.g. Prof. Kurt Fischer answering the question "What are the most exciting or promising areas of research into brain development and learning and memory—particularly pertaining to adolescents?" in Frontline, "Inside the Teenage Brain: The Teen Brain is a Work in Progress," online: Public Broadcasting Service <<http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/work/>> (30 August 2004); National Institute of Mental Health, "New Views on Brain Development," online: National Institute of Mental Health <<http://www.nimh.nih.gov/sciadvances/0005.cfm>> (30 August 2004); Jay N. Giedd, Jonathan Blumenthal, Neal O. Jeffries, F.X. Castellanos, Hong, Liu, Alex Zijdenbos, Tomáš Paus, Alan C. Evans, Judith L. Rapoport, "Brain Development During Childhood and Adolescence: A Longitudinal MRI Study" (1999) 2 Nature Neuroscience 861; Frontline, "Inside the Teenage Brain: Interviews: Jay Giedd, M.D.," online: Public Broadcasting Service <<http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html>> (30 August 2004).

<sup>167</sup> Spinks reports cautionary words from neuroscience researchers. See Sarah Spinks, "Inside the Teenage Brain: One Reason Teens Respond Differently to the World: Immature Brain Circuitry," online: Public Broadcasting Service <<http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/work/onereason.html>> (30 August 2004).

<sup>168</sup> Frontline, "Inside the Teenage Brain: Interviews: Deborah Yurgelan-Todd," online: Public Broadcasting Service <<http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/todd.html>> (30 August 2004).

As a result, while interesting, neuroscience insights into minors' development are unable to help shape the contours of our understanding of both adolescents' decision-making maturity, and when adolescents may be able to make medical treatment decisions as capably as we presume any adult can.

### **III. CONCLUSION**

When a minor asserts entitlement to decide the course of future medical treatment it is hard to predict whether, as an empirical matter, she will be found to be a mature decision-maker in relation to that decision. Research into minors' cognitive development reveals that minors aged 14 years of age and older are likely sufficiently mature in terms of their abstract cognitive functioning. Yet, there is insufficient research into the effects of illness, stress, emotions and motivations to be able to determine whether such capability extends to all fact situations.

Similarly, while we know which psychosocial aspects of development are critical to mature decision-making, we do not yet know how those features interrelate, and what level of development is necessary for a mature treatment decision. It is also difficult to know what weight to place on psychosocial capabilities as compared with cognitive functioning; while both branches of competency are critical to mature decision-making, it remains unclear how the two domains of development interrelate in the context of a particular decision. Further neuroscience research is necessary before we can draw any conclusions on the physical limitations brain development imposes on the maturity of minors' decisions.

The current state of neuroscience and psychology research thus suggests that we cannot, and should not attempt to generalise about the development of decision-making maturity. Klaczynski et al. summarise the current sentiment among psychology researchers, and state that "stage-conceptualisations of decision-making competence are unlikely to prove useful. Increasingly, theorists have recognised that a core characteristic of development is

variability. Different aspects of the self, including those relevant to decision making, develop along different timetables.”<sup>169</sup> Given that researchers decline to draw arbitrary age-based dividing lines for individual components of decision-making maturity, there seems little justification for legislatures and courts to rely on arbitrary age-based rules to determine difficult questions of entitlement to decide. Part Five translates this insight into a *Charter*-based argument, and asks whether s.1 of the *Charter* can justify rights-violations that result from legal reliance on arbitrary age-determined rules and presumptions of “maturity.”

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<sup>169</sup> Klaczynski et al., *supra* note 142 at 232.

## PART FIVE: *CHARTER* PROTECTION FOR MINORS' MATURE HEALTH CARE DECISIONS

### I. THE EXTENT OF *CHARTER* PROTECTION UNDER THE CURRENT LEGAL FRAMEWORK

Sections 2(a), 7, and 15 of the *Charter* provide potential sources of protection for minors who wish to have their health care determinations respected.<sup>170</sup> Minors may use these provisions to challenge either the legal rules that override or deny their maturity or the application of these rules to individual circumstances.

However, Canadian judges have generally rejected minors' *Charter*-based arguments against the authorisation of forcible medical treatment.<sup>171</sup> Case-law focuses on minors who have refused critical health care, rather than non-essential medical treatment. Judges tend not to engage in detailed reasoning on *Charter* arguments in this context. Further, while raised in a significant majority of reported cases in common law jurisdictions, there is a distinct lack of discussion of *Charter* issues in the Québec case-law;<sup>172</sup> consequently, Part Five centres its treatment of *Charter* issues on Canadian common law jurisdictions.

The Supreme Court of Canada has not yet granted leave to appeal in any case concerned with minors' entitlement to make critical medical treatment decisions. Of the three exceptional cases in which minors have been held entitled to refuse potentially life-saving medical procedures (*A.Y.*, *L.D.K.*, and *Walker*), only in *L.D.K.* did *Charter* analysis form part of the *ratio* for declining to authorise the forcible administration of treatment. In cases in which the authorisation of forcible medical treatment has been held justified, judges have held either that

<sup>170</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK) 1982*, c. 11 [*Charter*].

<sup>171</sup> But see *L.D.K.*, *supra* note 32, discussed below.

<sup>172</sup> But see the detailed analysis of the question whether the relevant CCQ provisions can withstand *Charter* scrutiny in Robert P. Kouri and Charlotte LeMieux, "Les Témoins de Jéhovah et le Refus de Certains Traitements: Problèmes de Forme, de Capacité et de Constitutionnalité Découlant du Code civil du Québec" (1995) 26 R.D.U.S. 77. But see exceptionally *Protection de la Jeunesse – 599*, *supra* note 71 at 615 (Justice Tremblay discusses s.1 of the *Charter*).

the particular *Charter* right in question was not violated or that s.1 justified any violation found. Judges tend not to explain why either approach is preferable to the other in any particular case; analysis of the case-law seems to suggest there is no principled distinction between cases in which s.1 is considered the appropriate justification and cases in which it is the scope of the right itself that should be confined.<sup>173</sup>

## A. Section 2(a): The Right to Freedom of Religion

In no case has the forcible imposition of medical treatment against a minor's wishes been held to violate the minor's s.2(a) *Charter* right to freedom of religion.<sup>174</sup> In the Ontario case of *S.H.*,<sup>175</sup> Justice Wilson denied a 13-year-old Jehovah's Witness's challenge to medical treatment imposed against her wishes. Justice Wilson did not distinguish between the correctness or preferability of reasoning that s.1 justified an infringement of the s.2(a) *Charter* right, rather than that s.2(a) had not been infringed in the first place; for Justice Wilson, the two arguments were readily interchangeable. Justice Wilson did not explain why, in the result, he chose to adopt the latter approach, but simply argued that s.1 justified the imposition of treatment under the *Oakes* test<sup>176</sup> because the minor was not a capable decision-maker.<sup>177</sup> If this supporting claim is correct, the result in *S.H.* seems justifiable despite Justice Wilson's confused reasoning.

In the more recent Alberta case of *B.H.*, Justice Kent preferred the argument that the s.2(a) right was not absolute and could give way to an order made in an adolescent's "best interests."<sup>178</sup> Rather problematically, Justice Kent relied on Justice La Forest's statement in the

<sup>173</sup> See e.g. *S.H.*, *supra* note 5, discussed below.

<sup>174</sup> This might have been otherwise had a s.2(a) challenge been brought in *L.D.K.*, which is the only case in which forcible administration of medical treatment against a minor's mature treatment decision has been held to violate a minor's s.7 and s.15 *Charter* rights. See discussion below; *L.D.K.*, *supra* note 32.

<sup>175</sup> *S.H.*, *supra* note 5.

<sup>176</sup> *R. v. Oakes*, [1996] 1 SCR 103 [*Oakes*].

<sup>177</sup> *S.H.*, *supra* note 5, Wilson J. at para.112.

<sup>178</sup> *B.H.* (Alta. Q.B), *supra* note 2, Kent J. at para.55.

Supreme Court of Canada in *B.(R.)* to reach this conclusion;<sup>179</sup> yet, Justice La Forest himself understood s.1 as the better mechanism for saving such state intervention.

## **B. Section 7: The Right to Liberty and Security of the Person**

The absence of clear doctrinal reasoning is also evident in the case-law treatment of s.7 challenges. In *L.D.K.*,<sup>180</sup> a 12-year-old minor used s.7 of the *Charter* to successfully dispute the forcible imposition of treatment. The minor was a member of the Jehovah's Witness faith, as were both her parents. She had been diagnosed with acute myeloid leukaemia, and had refused blood transfusions, while also strongly objecting to chemotherapy, whether or not accompanied by transfusions. Although the staff at the hospital knew her objections, they administered one transfusion without consulting either the minor or her parents.

Judge Main found that s.7's procedural requirements had been violated through lack of consultation, and that the actual imposition of a transfusion on the minor – held a “mature minor” who was not a “child in need of protection” under provincial child welfare legislation – also violated s.7's substantive requirements.<sup>181</sup> But, as discussed above, L.D.K.'s poor prognosis for recovery was a significant factor in the decision reached.<sup>182</sup> It is unclear, therefore, to what extent we can place any weight on the fact that the minor's s.7 *Charter* right was held to have been unjustifiably violated in this case.

Unsuccessful s.7 *Charter* challenges have resulted from judges finding that the authorisation of forcible medical treatment satisfied the principles of fundamental justice on the facts.<sup>183</sup> But there has been little judicial analysis of precisely how the requirements of fundamental justice were satisfied in individual cases. In *S.H.*, Justice Wilson held that the court

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<sup>179</sup> *B.(R.)*, *supra* note 48, La Forest J. at para.107 (speaking for the majority of the Court).

<sup>180</sup> *L.D.K.*, *supra* note 32.

<sup>181</sup> *Ibid.*, Main Prov. Ct. J. at para.31.

<sup>182</sup> See Part Three, sections I and III above.

<sup>183</sup> See e.g. *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at para.51-52.

hearing by which forcible treatment was authorised complied with the principles of natural justice, and that this was tantamount to satisfying the procedural requirements of fundamental justice under s.7.<sup>184</sup> But Justice Wilson did not consider the more difficult question of whether the substantive aspects of the right to liberty and security of the person were also satisfied, although the minor had not made this issue explicitly part of her argument.

Justice Kent addressed the substantive requirements of fundamental justice in *B.H.*; he contended that they were satisfied on the facts because the limits imposed on the minor's control over her own body were neither "arbitrary" nor "unfair,"<sup>185</sup> but necessary to promote the well-being of an adolescent whose life was in jeopardy.<sup>186</sup> But this analysis cannot justify Justice Kent's conclusion in relation to s.7; the impulse to act to preserve a minor's life and secure her "best interests" may govern judicial action only if that minor should *not* be treated as an adult in law, namely as entitled to make decisions contrary to her (externally perceived) "best interests." Justice Kent's comments illustrate that the key factor that determines whether a minor's mature treatment decision should be protected by the s.15(1)(1) equality right also underpin that minor's claim to protection of her freedom to make her own treatment decisions under s.2(a) (where her decision is religiously-based) and s.7 of the *Charter*. This argument is explained in detail in the following section, and forms the basis of my proposal for law reform.

### **C. Section 15: The Right to Equal Protection and Equal Benefit of the Law**

Under the current law, the s.15 equality right has not generally been applied to protect a minor's mature decision to refuse critical medical care. No s.15 challenge has been brought before the Québec courts. Kouri and LeMieux suggest, however, that certain minors who make mature

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<sup>184</sup> *S.H.*, *supra* note 5, Wilson J. at paras.61-76.

<sup>185</sup> *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at para.51.

<sup>186</sup> *Ibid.*, Kent J. (citing *B.(R.)*, La Forest J. at para.88 (speaking for the majority of the Supreme Court of Canada)). See *B.(R.)*, *supra* note 48.

treatment decisions may successfully challenge the legislative denial of a right to refuse treatment under s.15 of the *Charter*; they argue that overriding minors' mature treatment decisions constitutes a violation of s.15 that cannot be justified under s.1. The exclusion of the right to refuse treatment from the autonomy rights of minors who are 14 years of age or older is not proportionate to the goal of protecting all minors from harm to their physical well-being. The exclusion of the right to refuse is, Kouri and LeMieux contend, "non seulement arbitraires et peut-être inéquitables, mais que [les moyens] constituent également une entrave à la liberté du mineur apte."<sup>187</sup>

In common law provinces, only in *L.D.K.* has s.15 been held violated in a manner not justified by s.1. In that case, Judge Main held that L.D.K. had been unjustifiably discriminated against on the basis of her age (12 years) and religion. In *B.H.*, in contrast, Justice Kent contended that while s.15 was violated on the facts, the violation was justified by s.1. Justice Kent's argument centred around the claim that, while the age restriction upon entitlement to make treatment decisions is arbitrary in Alberta (set at 18 years of age, the age of majority), that restriction represents a reasonably well drawn arbitrary dividing line between entitled and non-entitled minors. "Some age must be chosen and, whatever it is, it will necessarily be somewhat arbitrary," Justice Kent contended, "but, provided, that it is within a reasonable range and age 18 is, I am prepared to find the choice of 18 justifiable."<sup>188</sup>

But Justice Kent incorrectly presumed the necessity for determining minors' authority to make health care decisions by means of an age-based rule of entitlement. The need for an arbitrary age-based dividing line remains to be demonstrated and, therefore, cannot underpin Justice Kent's defence of the violation of s.15. The following section develops the argument that the s.15 equality right is properly understood as securing to minors the entitlement to make medical treatment decisions that correspond with their decision-making maturity.

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<sup>187</sup> Kouri and LeMieux, *supra* note 172.

<sup>188</sup> *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at para.47.

## II. CONCEPTUAL FRAMEWORK FOR A MINOR'S s.15 CHARTER RIGHT TO HAVE HER MATURE TREATMENT DECISION UPHeld IN LAW

A minor's s.15 *Charter* challenge to legislative or judicial authorisation of forcible, involuntary medical treatment turns on whether she is being treated differently from an adult by reason of her age only.<sup>189</sup> If a minor can demonstrate that she possesses the same decision-making maturity as an adult is expected to have when entitled to make health care decisions, it must be because of her age alone that the legislature and courts choose to override her decision. Further, if a minor can successfully demonstrate sufficient decision-making maturity to entitle her treatment decision to the same respect in law as would be given an adult's decision, that maturity helps ground additional *Charter* claims under s.2(a) and s.7.

The constituent elements of the s.15 challenge thus act as a keystone to the minor's full range of protective rights under the *Charter*. If a minor has reached her decision in a mature manner, the fact that her decision is religiously-based, cannot be reason to override her decision. Similarly, the desire to protect a minors' health cannot provide justification for violating her right to liberty and security of the person, if her refusal to consent to the administration of treatment should be respected to the same extent as an adult's decision. In the final section of Part Five I demonstrate that s.1 policy arguments are incapable of saving violations of either a minor's s.15 right or, concomitantly, her s.2(a) and s.7 *Charter* rights.

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<sup>189</sup> This discussion focuses only on the aspect of the *Law* test that is most difficult for minors' entitlement to make health care decisions – that the impugned law distinguishes between minors who make mature treatment decisions and adults on the basis of personal characteristics (here: age). See *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497 [*Law*]. The second limb of the *Law* test (the differential treatment requirement) is satisfied where minors' mature treatment decisions are overridden, or their maturity is denied. The third limb of the *Law* test (the "human dignity" requirement) should also be satisfied, since it is respect for persons and individuals' inherent human dignity that underpins adults' entitlement to make treatment decisions that conflict with the state's interest in their physical health. In other contexts, it may often be the third inquiry that creates most difficulty for judges, at least in part because of the malleability of the concept of "human dignity." For an illuminating discussion of the "human dignity" question, see Colleen Sheppard, "Inclusive Equality and New Forms of Social Governance" (2004) 14 *Supreme Court Law Review* (2d) (forthcoming).

## A. Section 15 and the Value of Autonomy

In the sense that immaturity is a restriction on minors' freedom of action in society, maturity is shorthand for autonomy. An adult does not possess a right against coercive medical intervention simply because she has made an autonomous decision, but because it fits our collective values to respect her autonomy.<sup>190</sup> As a liberal society, we value a society of individuals who live their own lives, individuals who are "authors" of their own moral lives.<sup>191</sup>

John Harris summarises the nature of the social value placed on autonomy:

[O]n the political level, a society will always have a strong interest in developing the autonomy of its citizens. For only autonomous citizens will have the ability to participate meaningfully in government and in political and social decision-making. Moreover, only self-determined critically aware citizens will have the ability to detect and combat the abuses of power which are endemic in complex societies.<sup>192</sup>

As a result, a mature or autonomous decision implicates not only the process of reasoning employed in reaching that decision, but also the value system – the tools with which an individual authors her own life – that informs an individual's decision-making process. A minor's s.15 argument thus depends not only upon her cognitive and psychosocial maturity, but also upon her beliefs and values.

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<sup>190</sup> In other words, the state interest in the preservation of life cannot simply be overridden in the name of freedom of autonomy. In the Supreme Court of Canada judgment in *Rodriguez*, the majority emphasised that respecting the patient's decision constituted the exceptional outcome. Although the decision related to assisted suicide, the court considered patients' entitlement to refuse medical treatment more generally. Justice Sopinka, speaking for the majority, asserted that "Canada and other Western democracies recognise and apply the principle of the sanctity of life as a general principle which is subject to limited and narrow exceptions in situations in which notions of personal autonomy and dignity must prevail." See *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, Sopinka J. at para.168 [*Rodriguez*]. In terms of theoretical discussion on the interplay of coercion and autonomy, see Joseph Raz, *The Morality of Freedom* (Oxford, U.K.: Clarendon, 1986) at 148-57, 207.

<sup>191</sup> Raz, *ibid.* at 204.

<sup>192</sup> Harris, *supra* note 39 at 213.

## **B. Psychological Components of a Mature Decision**

Earlier discussion of the social science literature demonstrated that certain minors may be as cognitively and psychosocially mature as adults.<sup>193</sup> But the force of these research conclusions is tempered by the fact that very few studies have directly compared the decision-making capabilities of individuals of different ages (e.g. young minors, adolescents, adults).

Nevertheless, the available research makes it clear that there is no age at which all minors, or even the majority of minors, acquire the decision-making competencies that we presume are possessed by the adult population.

Instead, the particular decision-making context, and the minor's unique experiences and capabilities combine to determine whether any one decision should be understood as mature. Further, this determination may have to be reached by deciding what weight to place on the presence of particular cognitive or psychosocial abilities despite the absence of others, since the many skills develop at different rates. The important point is that, despite these complications in determining the outcome in individual cases, there is evidence to support recognising certain minors' health care decisions as mature.

## **C. Substantive Requirements of a Mature Decision**

In addition to a positive assessment of the minor's cognitive and psychosocial competencies, including the absence of any undue influence or coercion, a mature decision must satisfy certain substantive conditions: first, the minor must possess a relatively stable set of informing values; second, this value-basis must be socially tolerated; third, regardless of the minor's competence to make a mature decision, the actual process of decision-making in the particular case in question must not be irrational. These restrictions upon an individual's entitlement to make

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<sup>193</sup> See Part Four above.

health care decisions reflect presumptions made about adults' decisions that enable them to make their lives their own.

These substantive requirements have been the subject of recent debate in the medical philosophy literature as they pertain to the idea of rational suicide.<sup>194</sup> In order to be held entitled to make her own treatment decision, a minor must demonstrate that her decision is based upon a relatively stable set of informing values. There exists no similar requirement that an adult must ground her health care decision in a relatively stable set of values. Yet, while an adult is entitled to refuse critical medical treatment for capricious reasons,<sup>195</sup> such a decision is likely to cause us to question her psychological capabilities and understanding. It is presumed that most adults *do* base their decisions on a relatively stable set of beliefs. I suggest that it is only a small concession to paternalism to require that a minor demonstrate (e.g. through conversation with physicians, psychologists or the court) that her decision is underpinned by what she believes are her enduring beliefs and values.

In addition to being relatively stable, the value-basis of the minor's decision must be socially accepted before the minor will be held legally entitled to make a particular health care decision.<sup>196</sup> This restriction upon a minor's entitlement to decide the course of one's future treatment is justified by reanalysis of the notion of respect for autonomy. An individual's sphere of autonomous action is not, and should not be equivalent to the sphere within which she can make rational decisions. Yet, granting another individual decision-making autonomy is about recognising that our values, society's values, coalesce with hers.

Choron comprehends this aspect decision-making maturity as the requirement that the decision-maker's set of informing values "... seem justifiable, or at least "understandable," to the

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<sup>194</sup> See e.g. Jacques Choron, *Suicide* (New York, N.Y.: Charles Scribner's Sons, 1972); Jan Narveson, "Moral Philosophy and Suicide" (1986) 31 *Canadian Journal of Psychiatry* 104; Margaret Pabst Battin, *The Death Debate: Ethical Issues in Suicide* (Englewood Cliffs, N.J.: Prentice Hall, 1996) 131-55; C.G. Prado, *The Last Choice: Preemptive Suicide in Advanced Age*, 2nd ed. (New York, N.Y.; Westport, Ct.: Greenwood & Praeger Presses, 1998).

<sup>195</sup> Harris, *supra* note 39 at 203.

<sup>196</sup> See e.g. Choron, *supra* note 194, c.11. Prado critiques Choron's interpretation of this requirement. See Prado, *supra* note 194 at 49.

majority of his contemporaries in the same culture or social group.”<sup>197</sup> Choron’s interpretation risks over-relativizing the accessibility requirement by including reference to a social group that may not share the beliefs of broader society (e.g. doomsday cult), this requirement is nevertheless a key component of a mature decision.<sup>198</sup> In a case in which a minor wishes to make her own treatment decision, therefore, the better interpretation is that the values underpinning her decision must be considered accessible to the majority of a modern *pluralistic* society.

The third substantive criterion for mature decision-making relates to the “irrationality” of the decision. “Irrationality” signifies impaired reasoning (e.g. making a fear of needles decisive among the factors that speak for and against a particular critically necessary medical procedure); such impaired reasoning cannot underpin a mature treatment decision. However, one might question the need for the irrationality criterion: do not the cognitive and psychosocial requirements for mature decision-making prevent irrational decisions from being recognised as “mature”? I suggest not. The required level of cognitive development relates to the minor’s potentiality to make a mature decision, and thus does not consider the irrationality or otherwise of any particular decision. While certain psychosocial requirements for mature decision-making stress aspects of an individual decision, these requirements do not catch all those cases in which a minor may be making an irrational decision such as, for example, a refusal based on a fear of general anaesthetic and “being put to sleep.” The psychological aspects of mature decision-making are thus by themselves insufficient to ensure minors in need of society’s protection are not permitted to make decisions with serious consequences.

Further, a “rationality” test would be inappropriate because, while no irrational decision can be mature, not all mature decisions are rational. A religiously-grounded decision, for example, may not be rational since reliance on faith means that the decision cannot be based

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<sup>197</sup> Choron, *supra* note 194 at 97.

<sup>198</sup> Prado, *supra* note 194 at 49.

on a logical progression of provable propositions; yet, a faith-based decision is not opposed to logic, and so should properly be considered arational, rather than irrational. As a result, it is best to test for “irrational” decisions and exclude those decisions only from the range of those capable of being held mature.

#### **D. Conclusion**

It is unclear how many minors who make cognitively and psychosocially mature decisions would also meet the additional substantive criteria set out above. Yet, if minors are to be able to successfully claim that overriding their treatment decisions constitutes age-based discrimination, these additional criteria are necessary. In a sense, this s.15 equality argument presents a more stringent version of the “mature minor” doctrine, which may possibly be met by fewer minors; but, this more comprehensive analysis of mature decision-making enables s.15 to be employed to secure greater legal protection to those minors who meet the enhanced criteria. Substantive and psychological requirements thus combine to produce a compromise that recognises maturing minors’ special protected status in society while also granting them the fullest possible recognition of their autonomy-dependent right to equality under s.15 of the *Charter*.

### **III. SECTION 1 AND POSSIBLE JUSTIFICATIONS FOR DISCRIMINATION AGAINST MINORS’ MATURE TREATMENT DECISIONS**

A successful s.15 argument for age-based discrimination is insufficient to guarantee legal protection for a minor’s mature treatment decision since a court may yet conclude that s.1 justifies any particular violation of a minor’s s.15 equality right. Four types of policy-based argument tend to be raised under s.1 as justification for the current position. First, the argument

from administrative efficiency contends that minimising administrative time, costs, and labour justifies using an age-based rule, rather than individualised assessments of maturity, to determine entitlement to decision-maker status. Second, the correlation argument proposes that current provincial rules are justifiable because there is sufficient correlation between minors' decision-making maturity and the age at which minors become entitled to make their own health care decisions.

Third, the argument from international obligations contends that current provincial legal frameworks are justifiable because they meet Canada's obligations under the *CRC*.<sup>199</sup> Fourth, the protection argument suggests that, whatever other reasons may exist in favour of allowing a minor to decide the course of her own future health care, the overriding concern for minors' right to life and health will always justify failure to respect a minor's mature treatment decision whenever such a decision endangers the minor's life or health.

## A. Administrative Efficiency

One of the most important arguments raised against eliminating any age-based legal rules is administrative efficiency. In *B.H.*,<sup>200</sup> Justice Kent held that s.1 saved any violation of a minor's s.15 equality right.<sup>201</sup> Justice Kent gave various reasons for this decision, and quoted Peter Hogg's argument with approval:

[O]ur laws are replete with provisions in which age is employed as the qualification for pursuits that require skill or judgment. Consider the laws regulating voting, driving, drinking, marrying, contracting, will-making, leaving school, being employed, etc. In regulating these matters, all jurisdictions impose disabilities on young people, employing age as a proxy for ability. Such stereotyping is inevitably inaccurate, because individuals mature at different rates. In principle, the use of age could be eliminated, because each individual could be tested for performance of each function. Age is used as a

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<sup>199</sup> *CRC*, *supra* note 118.

<sup>200</sup> *B.H. (Alta. Q.B.)*, *supra* note 2.

<sup>201</sup> This statement is technically *obiter*, however, since Justice Kent concluded that the minor had lost her mature decision-making capabilities as the case progressed. See *B.H. (Alta. Q.B.)*, *supra* note 2, Kent J. at para.78.

qualification for no other reason than to avoid or reduce the administrative burden of individualised testing.”<sup>202</sup>

While Hogg is right that it would be impractical to test and re-test the capacity of every minor and adult who sought to exercise the right to vote, or the right to drive, the critical health care context is distinguishable in two crucial ways.

First, such cases are rare.<sup>203</sup> The cost of implementing a case-by-case assessment rule, therefore, would be minimal in the critical medical treatment context in comparison with abandoning the use of age as a proxy for maturity in many other contexts. Second, judges, health care providers, and capacity review boards are already equipped to test a minor’s decision-making competency because this involves essentially the same test as when analysing an adult’s competency. As a result, there is little force to the objection that individualised testing would be difficult to implement because of uncertainties about the appropriate procedure for and content of any test for maturity.

## **B. Correlation Between Current Age-Based Rules and Minors’ Decision-Making Maturity**

The argument from administrative efficiency is a wholly practical argument for age-based legal regulations in general. The second potential justification for s.15 discrimination presumes that the administrative efficiency argument has force in the particular context under consideration. The argument from correlation seeks to establish on the basis of empirical evidence that a particular age is the appropriate point at which to grant or deny a legal right in a certain context. Even though I suggest the administrative efficiency contention does not apply to the issue of minors and entitlement to refuse treatment, the possibility that administrative difficulties may

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<sup>202</sup> *Ibid.*, Kent J. at para.48 (quoting P.W. Hogg, *Constitutional Law of Canada*, looseleaf (Toronto: Carswell, 1997) at para.52.13).

<sup>203</sup> For this reason Sneiderman also distinguishes the facts of *B.H.* from the issue of minors’ entitlement to exercise decision-making autonomy in other contexts. See Sneiderman, *supra* note 6 at 489.

arise in applying a maturity-based framework across Canada makes it worthwhile to ask whether there is any force to the correlation argument.

Justice Kent also raised this argument as justification for employing the age-based rules contained in the *Child Welfare Act* to determine whether forcible treatment of B.H. was to be authorised. Justice Kent commented that “[s]ome age must be chosen, and, whatever it is, it will necessarily be somewhat arbitrary, but, provided that it is within a reasonable range and age 18 is, I am prepared to find the choice of age 18 justifiable.”<sup>204</sup> Justice Kent’s reasoning demonstrates the two presumptions that underpin the correlation argument: first, that all minors develop decision-making maturity at a sufficiently similar rate that it is justifiable to generalise acquisition of entitlement to make treatment decisions; and second, assuming that the first presumption is correct, 18 years of age is in fact “within a reasonable range” of when all minors acquire these decision-making competencies.

Earlier discussion of cognitive, psychosocial and neuroscience research into minors’ decision-making maturity casts doubt on both of these assumptions. Cognitive development has been shown to be significantly affected by the context under consideration, especially the minor’s previous experience with illness and response to stress. Research has also demonstrated that minors’ levels of psychosocial competence vary greatly across minors of the same age. This difficulty of generalising across minors of a particular age is exacerbated by the fact that each minor’s maturity has to be understood as uniquely dependent on the interrelation of the particular competencies she has developed, and each of these competencies has matured at a different rate to her other competencies. These considerations undermine the value of age as a proxy for decision-making maturity.

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<sup>204</sup> *B.H. (Alta. Q.B.)*, *supra* note 2, Kent J. at para.47. David Archard agrees, and suggests that arbitrary rules of entitlement to legal rights are acceptable if there is some correlation between the basis for drawing the distinction between rights-holders and non-rights-holders (here: age) and the reason for the existence of the right (here: decision-making maturity). See David Archard, *Children: Rights and Childhood* (London, U.K.: Routledge, 1993) at 58-69.

The second presumption that underpins the correlation argument must also be rejected. This result follows from the our rejection of both the argument from administrative efficiency, and the first presumption of the correlation argument – that all minors develop decision-making maturity at a sufficiently similar rate that it is justifiable to generalise acquisition of entitlement to make treatment decisions. There is no need to determine individuals’ access to their rights according to the attainment of an age that is merely “within a reasonable range” of when individuals acquire decision-making maturity if this brings no efficiency advantage, and if that age will inevitably be inaccurate because of the different stages of maturity attained by individual minors of any age. As a consequence, the correlation argument cannot justify determining minors’ entitlement to make health care decisions by applying an arbitrary age-based rule.

Eighteen years of age is not “within a reasonable range” of the age at which all minors acquire the requisite decision-making competencies anyway. Cognitive research indicates 14 years of age may be the most appropriate benchmark for any sort of generalised acquisition of capacity. Psychosocial research is much less clear, and does not support any particular age as a watershed point.

Law reform that simply lowered the age at which minors became entitled decision-makers would be inadequate. If Alberta, for example, reduced the age of entitlement to make treatment decisions from the age of majority to 14 years of age, we would still have some (perhaps not many) 13-year-olds that should be entitled to make their own treatment decisions, and some minors aged 14 or older who would need to have their decisions overridden by application of substitute decision-maker legislation. The only form of reform that would be survive s.15 scrutiny would be the adoption of an age-based *presumption* of decision-making maturity, which encompassed all potentially mature decision-makers. Thus Alberta would need to reduce the age of presumptive decision-making maturity to 12 years, and then provide for individualised assessment of any minor who was at least 12 years of age, who sought to make

her own treatment decision, and whose maturity was in any doubt. I discuss proposals for legal reform further in Part Six.

### C. Conformity with Canada's Obligations under the *CRC*<sup>205</sup>

The third potential justification for s.15 discrimination against a minor's right to make her own treatment decisions relates to Canada's international obligations, and is not so commonly considered by judges as the other s.1 arguments I discuss. In overriding the treatment decision made by a 16 and-a-half-year-old "mature minor" in *McGonigle*, Justice Russell pointed to the *CRC* as support for her decision; she contended that her approach

is consistent with Canada's obligations under the *U.N. Convention on the Rights of the Child* to make the best interests of the child a primary consideration in decisions affecting children, while allowing a child capable of forming an opinion the right to express it, and the right for that opinion to be given due weight in accordance with the age and maturity of the child.<sup>206</sup>

However, it is not at all clear that Justice Russell is right in her suggestion that the authorisation of forcible medical treatment contrary to a "mature" minor's wishes is in compliance with the terms of the *CRC*. The text of Article 12(1) of the *CRC* reads as follows:

States Parties shall assure to the child who is capable of forming their own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

The right contained in Art.12(1) is generally seen as a right to participate, not to decide.<sup>207</sup> But the logic of the provision suggests that there should come a point at which "the age and maturity of the child" can be accorded "due weight" only if the minor's opinion is upheld in law. This would be so even on the understanding that that minor is only "participating" in the decision-making process, rather than asserting entitlement to be the main decider. Unfortunately, neither the full ambit of Art.12(1), nor the relationship between Art.12(1) and the "best interests"

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<sup>205</sup> *CRC*, *supra* note 118.

<sup>206</sup> *McGonigle* (Alta. C.A.), *supra* note 8, Russell J.A. at para.38.

<sup>207</sup> Priscilla Alderson, "Young Children's Health Care Rights and Consent" in Bob Franklin, ed., *The New Handbook of Children's Rights: Comparative Policy and Practice* (London, UK: Routledge, 2002) 155 at 157.

requirement contained in Art.3 have yet been tested. At the very least, the uncertainty as to the proper interpretation of the Art.12(1) obligation undermines the merits of the argument that the *CRC* can be relied upon to justify the violation of a minor's s.15 right.

## D. Protection of Minors' Life and Health

The final argument judges make when authorising forcible medical treatment is rooted in society's concern for its most vulnerable. Justice Russell in *McGonigle*, for example, draws on "society's historical interest in preserving the life and well-being of minors"<sup>208</sup> as support for her decision to authorise forcible treatment of a "mature minor" against her wishes. In the earlier decision in *B.H.*, Justice Kent similarly referred to "the overriding concern for the protection of a minor's right to life and to health."<sup>209</sup> In earlier times, when we knew less about minors' abilities for mature interactions in society, this level of protection made sense. Yet, the interest in preservation of life and health has never been an absolute interest that overrides respect for autonomy in all circumstances.

The compromise between these guiding principles has long been resolved in favour of respecting an adult's decision to refuse necessary medical treatment. My analysis shows that some minors' treatment decisions are as mature as adults.' If age is in fact being employed as a mere proxy for maturity, therefore, the compromise between the societal interest in life and health, on the one hand, and the societal and individual value of autonomy, on the other, should similarly be resolved in favour of upholding minors' mature treatment decisions. It is difficult to defend protection that overrides a minor's wishes, where those wishes have been expressed in the mature manner that is the basis of all adult entitlement to make treatment decisions.

Furthermore, a holistic understanding of individuals' well-being suggests that it is may be in a minor's best interests in a particular case to permit her to decline health care considered

<sup>208</sup> *McGonigle* (Alta. C.A.), *supra* note 8, Russell J.A. at para.38.

<sup>209</sup> *B.H.* (Alta. Q.B.), *supra* note 2, Kent J. at para.49.

critical for her physical survival. Many now believe that looking to the continuing survival and physical health of the minor fails to encompass everything that determines whether a particular intervention would be in the minor's best interests. Instead, certain judges and health care providers<sup>210</sup> consider matters such as the minor's spiritual and emotional well-being as part of their analysis of her best interests. It is doubtful whether, in the modern Canadian legal landscape, the desire to preserve life and physical well-being is sufficient to justify age-based discrimination against a minor who maturely refuses critical health care.

## IV. CONCLUSION

The previous discussion demonstrates that certain minors are discriminated against within the terms of s.15 of the *Charter* when their mature health care decisions are overridden. None of the four main policy-based arguments adduced under s.1 provide a firm basis for failing to uphold minors' mature medical treatment decisions. As a result, there is no legal basis upon which for provincial legislatures and the courts may override minors' mature health care decisions.

A successful s.15 challenge also makes available to minors arguments under s.2(a) and s.7 of the *Charter*. There can be no justification for violating a minor's s.7 right to liberty and security of the person by the forcible imposition of treatment once it is established that age alone underpins the decision to override a minor's mature treatment decision, and that use of an age-based rule is not soundly grounded in policy. A successful s.2(a) claim follows from various findings that constitute a minor's s.15 challenge, namely that her value basis is relatively stable and socially accepted (though not necessarily agreed with by the majority of the population), and that she has not been unduly influenced by others in reaching her decision.

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<sup>210</sup> See e.g. *A. Y.*, *supra* note 105; *Walker*, *supra* note 7.

## **PART SIX: RECOMMENDATIONS FOR FURTHER CONSIDERATION AND LAW REFORM**

The knowledge that provincial legal frameworks need to be brought into conformity with obligations imposed by sections 15, 2(a) and 7 of the *Charter*, does not naturally suggest any method for effective remedy. Part Six discusses options for reform that focus on streamlining the number of legal doctrines that may determine case outcomes, achieving a consistent approach between provinces, and synchronising minors' legal status with their level of maturity.

### **I. REPEAL OF AGE-BASED RESTRICTIONS AND ENACTMENT OF MATURITY-ORIENTED LEGISLATION TO GOVERN MINORS' ENTITLEMENT TO DECIDE**

Provincial legislatures should give serious thought whether to repeal legislative provisions that deny minors who are at least 12 years of age the opportunity of becoming entitled to make their own treatment decisions (including refusing treatment). A presumption of decision-making maturity for either all minors, or all minors aged 12 and above, could provide a workable alternative that would survive *Charter* scrutiny. I address the proper nature of a "maturity" standard is addressed in section II.

The repeal of age-based rules for entitlement to make treatment decisions would make it easier to bring provincial laws into line with both the reality of some minors' psychological development, and the mature nature of the decisions some of them reach. Eliminating age-based rules would also lead to an alternative regime that does not unjustifiably violate minors' s.15 equality right as the various provincial age-based rules currently do.

A legislative presumption of decision-making maturity at 12 years of age would ensure both administrative efficiency for minors who had plainly made a mature treatment decision, and

that all minors who may have made a mature decision would have their cases heard and individualised assessments reached. While an absolute age-based rule, rather than an age-based presumption of maturity, may offer increased administrative efficiency, the compromise in the reduced efficiency of a presumption is more than compensated by the significant additional protection of the rights of minors who are at least 12 years old that a presumption of maturity provides.

If 16 and-a-half Candice Unland had been presumed a mature decision-maker, for example, would the outcome have been different? With the burden of proving her immaturity shifted onto Child and Family Services, it seems less likely that Candice would have had her refusal overridden. Whether it is the minor or the state that bears the burden of proof is an essential part of protecting minors' rights. Further, in potentially life-and-death treatment scenarios one cannot underestimate the dignity value a minor may experience as a result of having their voice heard.

Further research is necessary, however, before policy-makers decide whether it would be best to adopt legislation that presumed capacity for all minors or only for minors aged 12 and older. Given that both Ontario and Prince Edward Island have adopted legislative presumptions of decision-making capacity, it would be useful to examine the practical implications of implementing such an age-based presumption that would hope to categorise all potentially mature minors as presumptively mature.

## II. REDEFINING “MATURITY” IN MEDICAL DECISION-MAKING FOR THE PURPOSE OF HEALTH CARE AND CONSENT LEGISLATION

The current interpretation of a “mature” health care decision should be reformulated to incorporate criteria that reflect a minor’s level of psychosocial, as well as cognitive development, and that assess the qualities of the decision the minor has reached.

This reform proposal should be implemented through a reformulation of the conceptions of “maturity” and “capacity” contained in health care and consent statutes, rather than through reform to the common law standard. Legislative reform is more likely to bring greater certainty and consistency to the law than common law reform, which has created provincial inconsistencies over matters such as whether the “mature minor” doctrine applies to both consent to and refusal of treatment, and whether it grants the minors exclusive or merely concurrent entitlement to decide.

Reform to the common law “mature minor” may become appropriate, however, if the process of provincial legislative reform is unable to bring the law into line with the various *Charter* provisions expeditiously. If reform is effected through legislation, the amended provisions should expressly provide that the common law “mature minor” doctrine has been supplanted by these statutory reforms.

The social science literature suggests the broad outlines of a more appropriate understanding of capable decision-making than is currently employed in both legislative and common law tests for entitlement to decide. But this must be qualified by the fact that research has focused to date on minors’ abilities as an independent field of study. We need more research that directly compares minors’ and adults’ decision-making abilities before we can fix the test for minors’ mature decision-making; it is important to ensure that we do not set the benchmarks for “maturity” and “capacity” too high in comparison to adults’ abilities.

I suggest that the greater compromise of fundamental values in favour of societal interests may justify the restriction of a minor's decision-making freedom beyond that of an adult's. The effect of this justification, however, does not go beyond permitting us to require a minor to demonstrate her capabilities and that her decision has particular substantive features (e.g. a socially-accepted value basis), when we would simply presume these factors present if an adult made the same treatment decision.

Research into health care providers' views of legislative reform is highly recommended. Valuable insight would be gained from exploring questions such as whether practitioners thought the proposed reforms administratively workable, and whether practitioners would feel more secure in a decision to respect a minor's mature refusal of medical treatment under the recommended conception of "mature" decision-making than through the current legal test.<sup>211</sup>

### **III. LEGISLATIVE REMOVAL OF ANY CONTINUING ROLE FOR THE COURT'S INHERENT *PARENS PATRIAE* JURISDICTION**

Provincial legislatures should consider enacting legislation that expressly states that the *parens patriae* jurisdiction has been supplanted by (current and recommended amendments to) health care and consent legislation. The *parens patriae* jurisdiction is retained in many jurisdictions under the mistaken assumption that, without it, certain minors in need of medical treatment will fall through the protective regime of the law.

Consideration of child welfare provisions, such as the Newfoundland *Child, Youth and Family Services Act*,<sup>212</sup> demonstrates the perceived need for *parens patriae*: The Act applies to a "child" only, defined as a minor under the age of 16, and not to a "youth," defined as a minor

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<sup>211</sup> A study similar to Urman et al's survey of medical practitioners' views of Ontario's 1996 legislative reforms could fulfil this function. See Rachel Urman, Bernard Dickens, Christine Harrison, "Pediatric Health Care Physicians' and Surgeons' Views of Ontario's Health Care Consent Legislation" (1996) 4 Health L.J. 135.

<sup>212</sup> *Supra* note 33. "Child" and "youth" are defined in s.2(d) and s.2(o), respectively.

between 16 and 19 years of age. If a 17-year-old, for example, does not meet the criteria for a “mature minor,” it appears as though necessary treatment may not be imposed against her wishes. Yet, this is to overlook the possibility that a substitute decision-maker may be appointed under the *Advance Health Care Directives Act*<sup>213</sup> to make these critical decisions on her behalf, such as her parents or treating physician. Substitute decision-maker legislation fills the so-called “gap” similarly in other provincial jurisdictions.

Once this scenario is understood not to present a legislative omission, it is clear that there is no situation in which the court’s inherent jurisdiction is needed to resolve cases concerned with minors’ entitlement to make her own medical treatment decisions. A continuing role for *parens patriae* undermines not only the validity of other legal doctrines used to decide individual cases, but also respect for the equal moral worth of minors and adults and, more concretely, minors’ s.15 equality right.

#### **IV. HIERARCHY OF LEGAL DOCTRINES USED TO RESOLVE WHETHER A MINOR RECEIVES MEDICAL TREATMENT**

Provincial legislatures should consider amendments that make clear the relationship between the different doctrinal approaches to minors and health care decision-making and both health care and consent statutes and child welfare statutes. It should not be necessary to include either the common law “mature minor” doctrine or the *parens patriae* jurisdiction in this ranking because neither will play a necessary role if the various reforms recommended above are enacted.

Of the two remaining doctrines, rules contained in health care and consent statutes should take precedence over child welfare provisions. If a minor is held to have made a

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<sup>213</sup> *Supra* note 27.

“mature” decision within the terms of the applicable health care and consent statute, there is no justification for trumping this determination by applying child welfare provisions because the minor cannot be “in need of protection” from the consequences of her mature decision.

## **V. IMPROVING MINORS’ PARTICIPATION IN THE DECISION-MAKING PROCESS**

To ensure that Canada meets its obligations under Art.12(1) of the *CRC*, provinces should consider incorporating into health care and consent legislation a right for minors to participate in the health care decision-making process when their own decision is not sufficiently “mature” to be determinative. A statutory participation right may do little more than accord with health care providers’ current best practices; the Bioethics Committee of the Canadian Paediatric Society, for example, advocates as a principle of treatment that “children and adolescents ... be appropriately involved in decisions affecting them.”<sup>214</sup> A legislative right to participate is an important visible sign of respect for minors, which also recognises their gradual maturation through participation.

Minors’ wishes are generally taken into account as part of the “best interests” determination in the application of child welfare provisions. But if health care and consent legislation is understood to determine minors’ rights ahead of child welfare legislation (as I earlier suggested it should), it is important that the right to participate form part of the health care and consent legislative framework, which will usually determine whether a minor receives recommended treatment.

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<sup>214</sup> CPS, B04-01, *supra* note 151.

## **VI. FURTHER RESEARCH INTO THE APPROPRIATE EXTENT OF A MINOR'S RIGHT NOT TO INFORM HER PARENTS OF MEDICAL CONSULTATIONS AND INTERVENTIONS**

While a minor's mature treatment decision should entitle her to consent to and refuse treatment, it does not necessarily follow that she should also be entitled to make any treatment decision without her parents being informed of the nature of the medical intervention she has undergone or declined to undergo. A minor patient's confidentiality is highly controversial, especially in relation to matters such as abortion and access to contraception. Further research needs to investigate a minor's entitlement to absolute confidentiality between provinces for various medical consultations and procedures. Additional research is also necessary to consider the proper relationship between a minor's right to decide and her right not to have her parents informed.

## **VII. FURTHER RESEARCH INTO MEDICAL PRACTICE AND THE ROLE THAT LEGAL DOCTRINES PLAY IN "EVERYDAY" CASES**

As in other areas of law, it is the contested cases that drive the need for reform. In the medical treatment context, these disputed cases are concerned with the refusal of potentially or likely life-saving treatment, and the reasons for refusal tend to be religiously-grounded. But using these test situations to shape the development of the legal doctrines that govern entitlement to make treatment decisions risks negatively impacting the ability of the law to assist health care providers involved in meeting minors' more everyday medical needs.

Before policy-makers move forward with reform proposals, therefore, further research is needed into how physicians make use of the prevailing legal doctrines in standard cases. If a

13-year-old minor attends a doctor's clinic alone in Ontario, for example, and wishes to receive a free flu shot, does the doctor accept the minor's consent? Or does she telephone the minor's parents to ask for their consent, or at least to inform them of the treatment their child is about to receive? Do the solutions to everyday cases follow the framework that governs minors' entitlement to refuse critical health care?

Research into the role of maturity and legal regulation in standard treatment scenarios is also necessary for a better understanding of how suggested law reforms may impact upon the practice of everyday medicine with respect to minors. Do doctors in different provinces understand the nuances of their own provinces' legislation and approach to the common law "mature minor" doctrine? Would law reform bring significant benefits in the form of clarification of the governing legal rules for doctors? Or do current best practice and medical ethics mean that doctors already respect minors' mature treatment decisions in relation to standard medical interventions to the extent for which my analysis advocates?

## PART SEVEN: CONCLUSION

I have argued that age is an inadequate proxy for the maturity of a minor's medical treatment decision. There are three aspects to the schism between age-based rules and the reality of minors' development: first, there is no general level of psychological development at which we can categorise minors of the same age; second, the skills necessary for mature decision-making develop at different rates for each minor; third, because there is no single definition of a mature decision, individual minors may make mature health care decisions as a result of combinations of skills.

My analysis has highlighted how the autonomy granted to adults through the entitlement to make their own treatment decisions consists of a compromise between societal interests and individual values. The compromise adopted in relation to minors may be understood as more heavily in favour of societal interests than it is in relation to adults. But this description is only accurate insofar as it describes the need for minors to explicitly demonstrate the maturity of their decision (e.g. that their decision is based on a relatively stable set of values) while adults are presumed to have made mature decisions. When we overcome the paternalistic societal interest, the minor in question should be seen to have a s.15 *Charter* right to have her treatment decision accorded the same legal protection as an adult's decision. On the basis of her s.15 right, I have suggested that the minor may also benefit from rights under s.2(a) and s.7 of the *Charter*.

My analysis concludes by suggesting avenues for legal reform that might bring the current law into line with both *Charter* obligations and Canada's obligations under the *CRC*. However, these reforms may not result in more minors being able to make their own medical treatment decisions; minors will have to satisfy the recommended high maturity benchmarks in relation to their grounds and processes of reasoning before gaining *Charter* protection for their right to decide.

It is not clear to what extent we should generalise from the conclusions drawn in relation to minors and medical decision-making. The importance of context throughout my analysis suggests we cannot assume that similar conclusions will be reached in other contexts. My analysis suggests an approach to enacting, interpreting, and applying legal rules that would secure minors' rights under s.15 of the *Charter* if it were applied to other situations involving the exercise of autonomy rights.

Open discussion of what it is we presume when we describe an individual's actions or decision as "mature" may enable concerned adults to recognise that protecting all minors from the consequences of their decisions is unnecessary paternalism. In order for any law reforms to be effective, we need to convince the older generation of the status many minors hold as emerging citizens. Sometimes age may be a shorthand, a proxy upon which we may reasonably rely, but at other times age may be just a number.

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# APPENDIX A - Summary of Provincial Legislation Governing Minors' Entitlement to Make Health Care Decisions

PROVINCE	AGE OF MAJORITY?	STATUTORY HEALTH CARE AND CONSENT RULES?	DOES THE COMMON LAW "MATURE MINOR" DOCTRINE CONTINUE TO APPLY?	ROLE GIVEN TO CHILD WELFARE LEGISLATION?
Alberta	18; <i>Age of Majority Act</i> , R.S.A. 2000, c. A-6, s.1	No legislation that grants or denies any decision-making entitlement to minors	Common law "mature minor" does not continue to apply in Alberta.	The <i>Child Welfare Act</i> , R.S.A. 1984, c. C-8.1, currently in force as the <i>Child Welfare Act</i> , R.S.A. 2000, c. C-8, has supplanted the common law doctrine: <i>B.H. (Next friend of) v. Alberta (Director of Child Welfare)</i> , [2002] A.J. No. 518 (Alta. Q.B.), Kent J. at para.31; <i>C.U. (Next friend of) v. McGonigle</i> , [2000] A.J. No. 1067 (Alta. Q.B.); Clarke J. at para.22, [2003] ABCA 66 (Alta. C.A.), Russell J.A. at para.35.
British Columbia	19; <i>Age of Majority Act</i> , R.S.B.C. 1996, c.7, s.1(1)	"Best interests" Model; <i>Infants Act</i> , R.S.B.C. 1996, c. 223, s.17: (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 if an infant provides that consent, the consent is effective and it is not necessary to obtain a	Unclear whether common law "mature minor" doctrine continues to apply in B.C. Section 17 of the <i>Infants Act</i> may be held to supplant the common law doctrine, especially since inclusion of the "best interests" test goes beyond the "capacity" requirements for minors' entitlement to make health care decisions. Supported by Justice Huddart's contention in <i>Ney v. Canada (Attorney</i>	<i>Child, Family and Community Service Act</i> , RSBC 1996, c. 46, s.13(1)(f). Justice Huddart also held in <i>Ney</i> that the decision of a child or her parent may be overridden under the provisions of the predecessor to the 1996 Act.

		<p>consent to the health care from the infant's parent or guardian.</p> <p>(3) A request for or consent, agreement or acquiescence to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care</p> <p>(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</p> <p>(b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.</p>	<p><i>General</i>) (1993), 102 D.L.R. (4th) 136 (B.C.S.C.) at 147 the common law rules were codified in the predecessor to the current <i>Infants Act</i>.</p>	
<p><b>Manitoba</b></p>	<p>18; <i>Age of Majority Act</i>, C.C.S.M., c. A7, s.1</p>	<p>No legislation that grants or denies any decision-making entitlement to minors.</p>	<p>Yes, the “mature minor” doctrine has been held to persist in Manitoba law. Section 4 of the <i>Health Care Directives Act</i>, C.C.S.M. 1992, c. H27, incorporates two age-based presumptions of decision-making capacity in relation to advance directives: first, that a minor who is at least 16 years old is capable of making health care decisions; second, that a minor younger than 16 lacks the capacity to</p>	<p>Child welfare legislation has been denied an overriding role in Manitoba law: <i>Kennett Estate v. Manitoba (Attorney-General)</i>, [1998] M.J. No. 337 (M.C.A.), Scott C.J.M. at para.48.</p> <p><i>Child and Family Services Act</i>, S.M. 1985-86, c. C80.</p> <p><i>Child and Family Services Amendment Act</i>, 1995, c. 23, ss.25(2), 25(9): A court may not authorise treatment for minor 16 years of age or older,</p>

<p><b>New Brunswick</b></p>	<p>19; <i>Age of Majority Act</i>, R.S.N.B. 1973, c. A-4, s.1(1)</p>	<p><u>Mixed "Best interests"/Age-Based Model; Medical Consent of Minors Act</u>, S.N.B. 1976, c. M-6.1: 2. The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority. 3(1). The consent to medical treatment of a minor who has not attained the age of sixteen years is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner, dentist, nurse practitioner or nurse attending the minor, (a) the minor is capable of understanding the nature and consequences of a medical treatment, and (b) the medical treatment</p>	<p>make their own treatment decisions. As a result, it would be odd if minors who were at least 16 years old were not entitled at common law to make the same treatment decision at the time that treatment was required that they could make in advance.</p>	<p>unless it is satisfied that the minor is "unable to understand the relevant information necessary to make such a decision, or to appreciate the reasonably foreseeable consequences of such a decision."</p>
	<p><u>Mixed "Best interests"/Age-Based Model; Medical Consent of Minors Act</u>, S.N.B. 1976, c. M-6.1: 2. The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority. 3(1). The consent to medical treatment of a minor who has not attained the age of sixteen years is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner, dentist, nurse practitioner or nurse attending the minor, (a) the minor is capable of understanding the nature and consequences of a medical treatment, and (b) the medical treatment</p>	<p>Suggestion that the "mature minor" doctrine has been supplanted by the <i>Medical Consent of Minors Act</i> (at least within the sphere of operation of the Act): <i>Region 2 Hospital Corp. v. Walker</i>, [1994] N.B.J. 242 (N.B.C.A.), Hoyt C.J.N.B. at para.22 (considers the Act to have codified the common law doctrine).</p>	<p>make their own treatment decisions. As a result, it would be odd if minors who were at least 16 years old were not entitled at common law to make the same treatment decision at the time that treatment was required that they could make in advance.</p>	<p>unless it is satisfied that the minor is "unable to understand the relevant information necessary to make such a decision, or to appreciate the reasonably foreseeable consequences of such a decision."</p>
	<p><i>Family Services Act</i>, S.N.B. 1980, c. F-2.2, s.31(1)(g). Role of the Act is unclear. In <i>Walker</i>, Justice Turnbull relied on the <i>Family Services Act</i> to justify authorising medical treatment despite the minor's wishes: See <i>Region 2 Hospital Corp. v. Walker</i>, [1994] N.B.J. 174 (N.B.Q.B.). Yet, Justice Turnbull also stated that he was acting under the <i>parens patriae</i> jurisdiction, and considered that the <i>Medical Consent of Minors Act</i> did not apply to a minor who sought to refuse medical treatment. In reversing his decision, the New Brunswick Court of Appeal failed to clarify whether the <i>Family Services Act</i> should be considered applicable in the case of a minor who has made a mature treatment decision.</p>	<p>Suggestion that the "mature minor" doctrine has been supplanted by the <i>Medical Consent of Minors Act</i> (at least within the sphere of operation of the Act): <i>Region 2 Hospital Corp. v. Walker</i>, [1994] N.B.J. 242 (N.B.C.A.), Hoyt C.J.N.B. at para.22 (considers the Act to have codified the common law doctrine).</p>	<p>make their own treatment decisions. As a result, it would be odd if minors who were at least 16 years old were not entitled at common law to make the same treatment decision at the time that treatment was required that they could make in advance.</p>	<p>unless it is satisfied that the minor is "unable to understand the relevant information necessary to make such a decision, or to appreciate the reasonably foreseeable consequences of such a decision."</p>

<p><b>Newfoundland and Labrador</b></p>	<p>19; <i>Age of Majority Act</i>, S.N.L. 1995, c. A-4.2, s.2</p>	<p>and the procedure to be used is in the best interests of the minor and his continuing health and well-being.</p> <p>No legislation that grants or denies any decision-making entitlement to minors.</p>	<p>The common law doctrine has not been overridden by /codified in any legislation governing minors' entitlement to make health care decisions. Would suggest that the common law "mature minor" doctrine continues to have a role in determining whether minors aged younger than 16 are entitled to make their own health care decisions. This is supported by the fact that s.7 of the <i>Advance Health Care Directives Act</i>, S.N.L. 1995, c. A-4.1 presumes minors younger than 16 years old are incompetent for the purposes of making health care decisions. But this seems to affect their ability to appoint substitute decision-makers or make an advance health care directive only, and not to extend to their ability to their entitlement to make their own health care decisions. As a result, it would seem odd if a 16-year-old minor could make an advance directive where she refused certain types of treatments, but could not refuse those treatments in the absence of any such directive.</p>	<p><i>Child, Youth and Family Services Act</i>, S.N.L. 1998, c. C12.1. Since this Act applies only to minors younger than 16 years old, it cannot be used to override mature health decisions made by minors aged between 16 and 19 years old. If an older minor (16- to 19-year-old) were held incompetent, a substitute decision-maker would presumably be appointed in the same way as if the minor were an adult. In <i>A. Y., Re.</i>, [1993] N.J. No. 197 (Nfld. S.C.), Justice Wells accepted the arguments of a 15-year-old's lawyers that it was proper to take into account the wishes of a "mature minor" even if those wishes countermanded the minor's "best interests;" this suggests that he understood the "mature minor" doctrine as a possible exception to applicable child welfare rules (the earlier <i>Child Welfare Act</i>, R.S.N. 1990, c. C.12). But Justice Wells did not directly state this conclusion, and based his reasoning on the proper understanding of</p>
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					<p>“necessary medical treatment.” As a result, it is unclear what the relationship is between the <i>Child Youth and Family Services Act</i> and the common law doctrine.</p> <p><i>Child and Family Services Act</i>, S.N.W.T. 1997, c.13, s.7(3)(n).</p> <p><i>Children and Family Services Act</i>, S.N.S. 1990, c.5, s.22(2)(e).</p> <p><i>Child and Family Services Act</i>, S.N.W.T. 1997, c.13, c.7(3)(n).</p> <p><i>Child and Family Services Act</i>, R.S.O. 1990, c. C.11, s.37(2)(e).</p> <p>Unclear what role the Act has to play given the presumption of capacity, and the possibility that a substitute decision-maker can be appointed under the <i>Health Care and Consent Act</i> to make decisions on behalf of an incompetent minor. No case-law on point.</p>
<b>Northwest Territories</b>	19; <i>Age of Majority Act</i> , R.S.N.W.T. 1988, c. A-2, s.2	No legislation that grants or denies any decision-making entitlement to minors	Would suggest that minors’ entitlement to consent to medical treatment is still predominantly determined by the common law “mature minor” doctrine. No case-law on point. Unclear; no case-law on point. Would suggest the common law doctrine continues to have a significant role to play, given the absence of any overriding/codifying legislation.		
<b>Nova Scotia</b>	19; <i>Age of Majority Act</i> , R.S.N.S. 1989, c. 4, s.2(1)	No legislation that grants or denies any decision-making entitlement to minors	Unclear; no case-law on point. In the absence of governing legislation, would suggest that the common law doctrine continues to play a significant role in determining minors’ entitlement to make health care decisions.		
<b>Nunavut</b>	19; <i>Age of Majority Act</i> , R.S.N.W.T. 1988, c. A-2, s.2	No legislation that grants or denies any decision-making entitlement to minors	It is unlikely that the common law “mature minor” doctrine persists as a significant basis for determining minors’ entitlement to make health care decisions because s.4(1) of the <i>Health Care and Consent Act</i> seems to embody the “mature minor” standard. Further, discussion in the Ontario legislature at the time of the enactment of the <i>Consent to Treatment Act</i> , S.O. 1992, c.31		
<b>Ontario</b>	18; <i>Age of Majority and Accountability Act</i> , R.S.O. 1990, c. A.7, s.1	<u>Presumption of Capacity Model</u> ; <i>Health Care Consent Act</i> , S.O. 1996, c.2, Sch.A, s.4: <i>Capacity</i> 4(1). A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about			

<p><b>Prince Edward Island</b></p>	<p>18; <i>Age of Majority Act</i>, R.S.P.E.I. 1974, c. A-3, s.1</p>	<p>the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. <i>Presumption of capacity</i> (2). A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.</p>	<p>(similar to the 1996 Act re. consent rules) suggests the legislative intention that the common law doctrine codify the Act. No case-law on point.</p>	
		<p><u>Presumption of Capacity Model</u>; <i>Consent to Treatment and Health Care Directives Act</i>, R.S.P.E.I. 1999, c. C-17.2: 3(1). Every person is presumed to be capable of (a) giving or refusing consent to treatment; and making a health care directive, until the contrary is demonstrated. 3(2). Authority to give consent includes authority to refuse consent or revoke a consent previously given. 4. Every patient who is capable of giving or refusing consent to treatment has the right (a) to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in</p>	<p>Unclear. Given the presumption of capacity, it is unlikely that the common law “mature minor” doctrine should be understood to continue to have a significant role to play in determining minors’ entitlement to make health care decisions.</p>	<p><i>Child Protection Act</i>, 2003 S.P.E.I., c. C-5.1. Unclear what role the Act has to play in determining minors’ entitlement to make medical treatment decisions.</p>

<p><b>Québec</b></p>	<p>18: <i>Civil Code of Québec</i>, Art. 153</p>	<p>death; (b) to select a particular form of treatment from among those proposed by a health practitioner on any grounds, including moral or religious grounds; ....</p>	<p><u>Age-Based Model</u>; This issue is addressed in Arts. 14-18 CCQ and related provisions. Article 14 CCQ reads: [Para.1] Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor. [Para.2] A minor fourteen years of age or over, however, may give his consent alone to such care. If his state requires that he remain in a health or social services establishment for over twelve hours, the person having parental authority or tutor shall be informed of that fact. Article 17 CCQ reads: A minor fourteen years of age or over may give his consent alone to care not required by the state of his health; however, the consent of the person having parental authority or of the tutor is required if the care entails a serious risk for the health of the minor</p>	<p>No civil law equivalent to the common law "mature minor" doctrine.</p>	<p>Arts. 46 and 47 of the <i>Youth Protection Act</i>, R.S.Q., c.P-34.1 entitle the Director of Child Welfare to override a refusal given by a minor, including a minor who is at least 14 years old, and is therefore apparently entitled to make a treatment decision under Art. 14(2) CCQ. Art. 16 CCQ also entitles the court to authorise that a minor's refusal of treatment be overridden.</p>
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<p><b>Saskatchewan</b></p>	<p>18; <i>Age of Majority Act</i>, R.S.S. 1978, c. A-6, s.2</p>	<p>and may cause him grave and permanent effects. No legislation that grants or denies to minors any general entitlement to make medical decisions.</p>	<p>Unclear; no case-law on point. Given that no statutes override or codify the common law rule, would suggest it continues to apply. Section 3 of the <i>Health Care Directives and Substitute Decision Makers Act</i>, S.S. 1997, c. H-0.001, entitles any minor who is at least 16 years old or more to make an advance directive. As a result, it would be odd if minors aged 16 or older were not entitled to make the same treatment decision at the time that treatment was required that they could make in advance.</p>	<p><i>Child and Family Services Act</i>, S.S. 1989-90, c.-7.2. Applies to minors younger than 16 years old. Taken together with the <i>Health Care Directives and Substitute Decision Makers Act</i>, this suggests that minors who are at least 16 years old may not have their mature treatment decisions overridden (by either child welfare or health care and consent statutes).</p>
<p><b>Yukon</b></p>	<p>19; <i>Age of Majority Act</i>, R.S.Y. 2002, c. 2, s.1(1)</p>	<p>No legislation that grants or denies any decision-making entitlement to minors</p>	<p>Unclear; no case-law on point. In the absence of governing legislation, would suggest the common law doctrine continues to have a significant role to play in determining minors' entitlement to make health care decisions.</p>	<p><i>Children's Act</i>, R.S.Y.T. 1996, c.22.</p>

The above chart reflects the general legal position only. Specific treatment scenarios (e.g mental health care, entitlement to make an advance health care directive, admission to hospital) are often regulated separately, and may have minimum ages for the entitlement to make one's own health care decisions that differ from the general position.