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When Worlds Collide: The Legal Rights of Minors in Ontario to Direct Medical Treatment*

I met Mark on a hot July day. I was working as an ambulance attendant in Ontario. I had been assigned to provide emergency coverage for a children's triathlon. Mark was one of the competitors at the event. He was 11 years old. His parents had placed him "on the circuit" and had equipped him like a professional.

The first time my partner and I saw Mark he was on the running course, approaching the hill before the finish. Even from a distance, we could both tell he was struggling. His parents were yelling "Faster! Faster! You won't win if you don't hurry up. Don't be so lazy! Get going!"

As Mark battled with the final hill, I decided it was time to position myself closer to where I anticipated the action would take place. I reached the finish line just before Mark. The young athlete staggered across the line and fell to the ground, face first. When he made no further attempts to move, I ran over.

I realized that Mark was very ill, one of the sickest children I had ever seen. His skin was red and dry and his body was limp. His eyes were cloudy. I picked up the small body and ran to the ambulance. One of the race officials ran off to find the boy's parents. This turned out to be a mistake.

In the back of the ambulance, I doused Mark with cold water. I noted that his pulse was faster than I had expected. His blood pressure was low and his breaths were neither deep, nor very frequent. I decided that Mark needed my assistance to breathe. Mark started to come around when I assisted his breathing. I asked him if he knew where he was or who I was. His answers "ambulance" and "paramedic" were both correct. It was then that Mark's father opened the back door of the still stationary ambulance.

To my surprise, Mark's father's response to finding his son lying in the back of an ambulance, not breathing for himself, was to yell at the boy: "Get out of there! You look like a wimp. No son of mine is going to be found in the back of an ambulance." He told me to stop what I was doing. In an effort to change the man's mind, I asked my patient if he wanted me to take him to the hospital. Mark responded with "Yes . . . Go . . . Hospital . . .

** For Mark: Here's the answer I promised. With thanks to Professor Larry Wilson at the University of Windsor Faculty of Law and His Honour Judge D.W. Phillips for their encouragement. Also thanks to Bob Taylor, former manager of Northbrook Ambulance, for teaching me how to be a caring paramedic.*



Please.” Mark’s father countered with another order to stop treatment.

The Ontario Ministry of Health Emergency Health Services Branch’s interpretation of the law was that for a person to give consent to medical treatment, he or she must be 18 years old, although consideration could be given to the wishes of a 16-year-old. The only exception to this rule was where the minor is married. In all other cases, the wishes of the parents, where ascertained, had to be respected.¹ According to my training I was required to stop treatment and turn Mark over to his father. This training on the law of consent to treatment was incorrect, but I did not know that at the time.

While these events were transpiring, my partner was outside implementing another of her inspired plans. She ripped the carbon paper from between the sheets of one of our

1 The textbook at the time of these events was: *Ambulance and Emergency Care Program: Legal and Ethical Issues* (Thunder Bay: Confederation College, 1990) at 96.

patient treatment records. Then she made Mark's father fill out the "Refusal of Service" section – four times. While he was engaged in this activity, the parent was not present in the ambulance actively refusing treatment for his son. I continued treatment. My partner sought the assistance of a police officer who was directing traffic around the sporting event. Large men with guns tend to be persuasive speakers. Mark's father was convinced that he should allow his son to be transported to the hospital.

We rushed Mark to the Emergency Department. There, the doctors perceived an emergency situation and started treatment without waiting for the boy's parents to arrive. The young athlete was diagnosed to be suffering from a combination of exhaustion and dehydration. No further objections were raised regarding Mark's continued treatment, or the requirement that he spend the night in the hospital. He was released the next day and recovered fully. I, however, was left with nagging questions about the rights of children to direct their own treatment.

This paper will demonstrate the need for children to be able to make their own health care decisions where they understand the nature and risks of the proposed treatments. It will examine the law in Ontario regarding the capacity of minors to provide valid medical consent. It will argue that no legal restrictions should be placed on that capacity. Finally, this paper will demonstrate the need to inform both children and health care providers about the law relating to medical consent of minors.

Unfortunately, Mark's situation is not unique. His story may represent the most dramatic expression of the problems related to minors' medical consent. It is not, however, the most common expression of this problem. Many children avoid seeking treatment for their medical problems when they believe their parents will become involved. This may be the result of a conflict of values with their parents, or it may be the result of fear or embarrassment. Whatever the reason, a minor may be denied the opportunity to receive necessary medical treatment. In addition, a child may not be able to receive medical treatment requiring parental consent if the parents cannot agree to provide that consent.

Adolescents are inherently reluctant to discuss their medical problems with their parents. As they become more self-conscious, adolescents are embarrassed to talk to their parents about their bodies. They are often hesitant to discuss medical problems with their parents or with a health care provider in the presence of their parents.² Children may avoid seeking treatment for their ailments if they believe that treatment would require either parental consent or notification.³ This situation may develop even where there are no conflicts in values between parent and child.

Issues of great importance in children's health are often those most likely to result in conflict between parent and child. Some of the more important medical issues are those relating to birth control, pregnancy, abortion, sexually transmitted infections, substance abuse and addiction, nutrition and psychological problems.⁴ These are sensitive and embarrassing issues. They can cause conflicts in a child's family. If parents must be involved, children may avoid treatment out of "fear of parental disapproval or even retribution."⁵

2 Joseph E. Simon and Aron T. Goldberg, *Prehospital Pediatric Life Support*, (St. Louis: C.V. Mosby, 1989) at 6.

3 Katherine Catton, Valerie Farrer, and Wendy Graham, *Adolescent Beliefs and Practices Regarding the Law of Minor's Medical Consent: A Pilot Study*, (Toronto: University of Toronto, 1990) at 7, 9-10.

4 See above at 11, 15-16.

5 See above at 12.

Many children are often not as innocent as society suggests. They live in a world where sex and drugs are real issues in their lives. In the United States, half of all teenagers engage in sexual activity before they turn 19. By March, 1993, 1,167 American teenagers had contracted AIDS. Between 24 and 30 per cent of gonorrhoea cases are found among teenagers. Ninety per cent of high school students have used alcohol, 40 per cent have used marijuana, and at least ten percent have used cocaine.⁶ Medical problems may result from these behaviours. However, these are subjects that minors are loathe to discuss with their parents.

Many children are aware of the importance of the major health issues for their age groups. They are frequently very aware of the importance of getting medical help for their health problems. However, even a perceived requirement of parental consent can be an effective deterrent against minors seeking the help they need. They frankly discuss health care issues and the difficulties arising from any requirement of parental involvement on the Kids Help Phone Web Site Discussion Forum:

Posting: How can I find out the phone numbers of places that deal with testing of [sexually transmitted disease]? By this I mean without going to my normal doctor's office.

Response by "P.J. Knows": you can get STD testing at many walk in clinics. if you are under age though you might get hassled. You might want to try a hassle free clinic. They don't ask for i.d. and you don't need parental permission. If you need a number children help phone has tones [tonnes].⁷

This example shows the importance some children attach to avoiding parental involvement in sensitive health care decisions. It also shows how difficult this can be. Children are genuinely reluctant to seek medical help for STDs without a guarantee that their parents will not be involved. It appears that the child in the posting will not even go to his or her regular physician out of fear that his or her parents will find out.⁸ This is especially a concern where the youth is gay or lesbian.⁹

One strong argument against parental consent for medical care is the adverse effects such a requirement would have on abused children. Requiring abused children to seek the permission of their abuser to receive treatment for the abuse they have suffered is in some sense ludicrous. The following postings from the Kids Help Phone Web Site Discussion Forum on Birth Control illustrate this point:

Posting: I'm 13 and pregnant by my dad. He doesn't know. Should I tell him? Should I get an abortion? What if he doesn't want me to because of what will happen? I love him so much and I don't want to hurt his feelings... The same thing happened to [my sister] 4 years ago but she won't help me. She had an abortion but now she's sterile. I want to have kids one day but if I get an abortion I might not be able to. Help me PLEASE!!!!!!

Response by "pk": it's ok people. I forced a miscarriage on myself so nobody has to know now. Thanks anyway.¹⁰

Custody and access disputes can lead to equally devastating results. The "best interests of the child", a supposed central objective, are often overlooked by parents preoccupied with gaining an advantage in court proceedings. In those situations, parents may dispute

6 William Adams, "But Do You Have to Tell My Parents? The Dilemma for Minors Seeking HIV-Testing and Treatment" (1994) 27 The John Marshall Law Review 493 at 494-495.

7 Kids Help Phone Discussion Forum. Found at <http://forums.sympatico.ca/forum.cgi?khp-13@^98@.ee6bd6a> on March 16, 1997.

8 The existence of these types of concerns is noted: See note 3 at 65.

9 See note 6 at 496.

10 Kids Help Phone Discussion Forum. Found at <http://forums.sympatico.ca/forum.cgi?khp-7@1146@.ee6bb24/0> on March 16, 1997. Because these postings are anonymous, the facts cannot be verified.

each other's capacity to provide consent or they may express opposing wishes regarding treatment for their children. A health care provider may not get valid consent from anyone.

The Law in Ontario

Ontario has new legislation addressing issues of medical consent. The Health Care Consent Act¹¹ was enacted to clarify the law surrounding consent to treatment. Section 4(1) of the Act allows a "person" who is able to understand the proposed treatment and its consequences to make his or her own decision regarding that treatment. Furthermore, section 4(2) states that a "person" is presumed able to make his or her own decisions regarding treatment. Under sections 4(3) and 10(1), unless health care providers have reasonable grounds to believe that their patient does not understand the treatment or the possible consequences of giving or refusing consent, they must abide by the patient's expressed wishes. Health care providers may assume that they have obtained a valid consent or refusal from a "person" unless they have reason to believe otherwise.

It is important to note that the 1996 Consent Act does not define the term "person." There is no reason at law to interpret the term "person" as not including children. At common law, a human being becomes a "person" when it takes its first breath after birth. This was the holding of the Supreme Court of Canada in *R. v. Sullivan*.¹² In *Re "Baby R,"*¹³ the BC Court of Appeal specifically held that the definition of person included children.¹⁴ Furthermore, the term "person" in the Canadian Charter of Rights and Freedoms¹⁵ was explicitly held to include children under age 16 in *R. v. J.(R.)*.¹⁶ Therefore, at law, children are persons. As such they are presumed to be able to consent to their own medical treatment under the 1996 Consent Act. British Columbia has legislation giving children specific rights to direct their treatment.¹⁷ While the Ontario legislation does not specifically give rights to children, it is clear this was one of the intentions behind passing the 1996 Consent Act.

Further support for the interpretation of the 1996 Consent Act giving children the right to consent to their medical treatment is found in the records of the Ontario Legislature. When the Act was debated, the question of whether children should be given this right was discussed. The Ontario Legislature supported the proposition.¹⁸ Thus, the intent of the Ontario Legislature in enacting the 1996 Consent Act was to allow children to consent to their own medical treatment. The expressed intentions of the legislature should be respected when interpreting legislation.

Despite concerns regarding extending capacity to medical consent to children, the 1996 Consent Act did not change the law. The common law recognized that children could direct their own treatment. *Johnston v. Wellesley Hospital et al.*,¹⁹ a case of medical malpractice involving a minor, is a leading case in this area. One of the issues decided in that case was whether a 20-year-old minor could consent to medical treatment. Mr. Justice Addy of the Ontario High Court of Justice held that there is no "age of consent." There is no specific age at which a minor becomes legally capable of making their own medical decisions. Children can direct their own treatment if they can appreciate fully the nature and conse-

11 Statutes of Ontario 1996, chapter 2, [hereinafter the 1996 Consent Act].
 12 [1991] 1 Supreme Court Reports 489 at 503. See also the decision of Justice Robins in *Dehler v. Ottawa Civic Hospital* (1979), 25 Ontario Reports (2d) 748 at 757 (High Court of Justice).
 13 (1988), 15 Reports of Family Law (3d) 225 (British Columbia Court of Appeal).
 14 See above at 231.
 15 Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, chapter 11 [hereinafter Charter].
 16 (1982), 1 Canadian Rights Reporter 202 at 204 (Ontario Court of Justice (Provincial Division)).
 17 Infants Act, Revised Statutes of British Columbia 1996, chapter 223, section 17.
 18 Ontario, Legislative Assembly of Ontario, *Official Report of Debates (Hansard)*, No.130 (28 November 1996) at 5420.
 19 [1971] 2 Ontario Reports 103 (High Court of Justice) [hereinafter *Johnston*].

quences of the procedures in question.²⁰ According to this ruling, minors always had the right to consent or refuse treatment the nature and consequences of which they understood.

The Ontario Legislature entrenched the rule in *Johnston* in the Consent to Treatment Act, 1992,²¹ which was repealed and replaced by the current statute, the 1996 Consent Act. Section 6(1) of the 1992 Act recognized that a “person” could consent to medical treatment if that person understood the “nature” and “possible consequences” of the proposed procedures. Under the old Act, children could consent to treatment that they understood. This does not suggest that because a child understands a simple procedure, that child has the authority to give consent for all procedures related to that child’s health care. At law, it is recognized that children may be able to consent to some treatments, but not others. The determining factor is how well they understand the treatment.

The 1996 Consent Act embodied many of the principles found in the 1992 Act. However, the 1996 Consent Act was able to expand on many of the rights given to patients in the old statute. Both the 1996 Consent Act and the 1992 Act recognize that capacity to consent to medical treatment depends on both the ability of the patient to understand the treatment proposed and the time that the treatment is received. Section 15(1) of the 1996 Consent Act recognizes that a person can consent to some procedures, but not to others. A child may consent to procedures that he or she understands, such as an ambulance ride, but not to those that he or she does not understand, such as surgical treatment for a brain tumor.

Section 15(2) of the 1996 Consent Act and section 6(3) of the 1992 Act, recognizes that a person may be able to consent to treatment at one time, but not at another. These sections recognize that as children grow older, they can give valid consent to an increasing range of treatment. The ability to understand the proposed treatment and its associated risks is the requirement for consenting to it under the 1996 Consent Act.

The 1996 Consent Act did expand on section 6 of the 1992 Act. Section 16 recognizes that during treatment, a pediatric patient may develop the level of understanding required to give consent. When this happens, health care providers must respect the young patient’s choices, over those of the parents, regarding continued treatment. This section applies to children suffering from chronic diseases. At age six, they may not understand the treatment they are receiving. As they grow older, these children may develop a greater understanding of their diseases and their treatments. When a child understands both the nature of the treatment and the risks associated with continuing and ending it, that child is able to make his or her own decisions regarding that treatment. The old Act did not specifically give a person the right to make his or her own decisions regarding treatment after someone else provided the initial consent.

The 1996 Consent Act differs from the 1992 Act in one important aspect. It allows a health care provider to presume that a person, including a child, is competent unless there is reason to believe otherwise. This presumption did not exist for children before the 1996 Consent Act. According to the common law of the United States, minors are presumed to be

20 See above at 14-15.

21 Statutes of Ontario 1992, chapter 31 [hereinafter the 1992 Act].

incompetent to make their own treatment decisions.²² The only exceptions to this rule are where children are married, legally emancipated from their parents, or have sufficient maturity to comprehend and understand both the nature and risks of the procedure.²³ The “Mature Minor Doctrine” allows a child to argue that he or she has sufficient understanding of the proposed procedure to allow him or her to give valid consent. At common law, a court must make the determination whether a minor’s wishes can be respected.²⁴ Unless a statute provides otherwise, minors must be able to prove their understanding of proposed treatments before their wishes can be respected.

The New Brunswick Court of Appeal adopted the Mature Minor Doctrine in *Walker v. Region 2 Hospital Corp.*²⁵ The case involved a 15 year-old Jehovah’s Witness who refused life saving treatment for his leukaemia because it involved blood transfusions, which are not permitted by the Jehovah’s faith. In finding for the patient, Chief Justice Hoyt and Justice Angers held that he had “sufficient maturity” for his wishes to be respected.²⁶ Specifically, Justice Hoyt held that where minors can understand the nature and consequences of the proposed treatment, interference with their wishes cannot be justified.²⁷ However, the presumption was still that the minor was incapable of providing consent until proven otherwise.

In the *Walker* case, Mr Justice Ryan concurred in the result, but his reasons differed. He held that while mature minors could consent to medical treatment, they cannot always refuse it. The court should use its *parens patriae* jurisdiction to override the wishes of a parent or child to protect the child’s life if that life is in peril.²⁸ According to the facts in *Walker*, the boy’s life was not in immediate danger, so his wishes had to be respected. If his condition changed, Mr Justice Ryan would consider forcing him to undergo treatment. This opinion would give “mature” children the right to consent to medical treatment, but limit their right to refuse it.

The Mature Minor Doctrine was employed to interpret the 1992 Act in *Children’s Aid Society of Metropolitan Toronto v. S.H.*²⁹ This case concerned a protection application to have a 13 year old Jehovah’s Witness made a ward of the Children’s Aid Society so that the hospital could administer a blood transfusion. The mother refused to consent to her daughter’s treatment because of her daughter’s opposition to it. The judgment of the Ontario Court (General Division) referred to “milestones” in other pieces of legislation to determine whether a minor has capacity to consent to medical treatment. Specifically, Justice Wilson looked to the age when people are allowed to drive and consume alcohol as an indication of their ability to make good decisions. The creation of such limits was interpreted as evidence that children cannot make decisions for themselves.³⁰ Further, Justice Wilson held that section 37(3) of the Child and Family Services Act³¹ created a presumption that children do not have capacity to make their own decisions until they reach the age of 16. That section requires the court to take several criteria into account when making an order or determination of the “best interests of the child” in a protection application. The section applies to children under age of 16 and cites the “child’s views and

22 Alexander Morgan Capron, “The Competence of Children as Self-Deciders in Biomedical Interventions” in Willard Gaylin and Ruth Macklin, eds., *Who Speaks for the Child: The Problems of Proxy Consent* (New York: Plenum Press, 1982) 57 at 59, 74.

23 See above at 70.

24 See above at 73-74.

25 (1994), 4 Reports of Family Law (4th) 321 at 333.

26 See above at para 31, 42.

27 See above at para 25, 29.

28 See above at para 66-70.

29 [1996] Ontario Judgments No 2578 (QuickLaw) (General Division) [hereinafter cited to QuickLaw as *S.H.*].

30 See above at para 95-96.

31 Revised Statutes of Ontario 1990, chapter C-11 [hereinafter *CFSA*].

wishes" as one criteria in the determination.³² It does not specifically state that children lack capacity to make medical decisions. The Court used all these considerations to override the expressed wishes of the minor patient.

Under the 1996 Consent Act, children in Ontario are presumed to be able to consent to and refuse medical treatment. To dispense with that consent or refusal, a health care provider must determine, on reasonable grounds, that the child does not fully comprehend the nature or the possible consequences of the decision. If reasonable grounds for invalidating the child's instructions cannot be found, those instructions must be followed, even where the parent's wishes contradict those of the child.

Many health care providers are reluctant to respect the wishes of a child over those of a parent. The reasons are simple. Parents usually have more opportunities for recourse. They are more likely to complain to any available authority if health care providers have not respected their wishes. In addition, compared with their child, parents are much more likely to sue. Children have more difficulty in having their views heard by a court.³³ However, section 29 of the 1996 Consent Act gives health practitioners protection from legal sanctions for abiding by a child's wishes. Section 29(1) states that practitioners who reasonably believe valid consent has been given are not liable for providing treatment. Sections 29(2) and 29(3) give practitioners the same freedom from liability for not providing treatment because they reasonably believe there has been valid refusal. Health care providers have no need to fear legal sanctions for respecting the treatment wishes of a minor where there is no reason to defeat the presumption that minors understand the decision they are making.

Before being revoked in 1996, section 26 of Ontario Regulation 965,³⁴ made pursuant to the *Public Hospitals Act*,³⁵ was a significant limit on the ability for children to direct their own treatment. It made it impossible for children under the age of 16 to undergo certain forms of treatment without parental consent. Section 26 of that regulation stated that no surgical procedure and no diagnostic test or medical treatment requiring written consent could be performed on a patient under 16 years of age without the consent of a parent or other person with legal custody. The only exception to this rule was where the young patient was married. The regulation applied to all publicly funded hospitals including all other "places" operated by the hospital for the treatment of the sick and injured.³⁶ The term "place" has been held to include the "office where a duly qualified medical practitioner is engaged in the practice of medicine or surgery."³⁷ Presumably hospital-run clinics were subject to Regulation 965. As the word "place" has also been interpreted to include vehicles,³⁸ hospital "mobile clinics" also had to comply with it. This regulation is still significant because many hospitals have not changed their procedures to reflect the change in the law allowing children under age 16 to provide valid consent.

The effect of section 26 of Regulation 965 was, and continues to be, devastating for children seeking medical treatment without involving their parents. They cannot go to a hospital or a hospital clinic for many procedures. Testing for sexually transmitted diseases usually requires written consent. Testing for HIV always requires written consent because of

32 *CFSA*, section 37(3)(10).

33 In Ontario, a minor must have an adult litigation guardian to commence an action.

Ontario, Rules of Civil Procedure, rule 7.04(1).

34 Revised Regulations of Ontario 1990, Reg. 965, section 26, as repealed by Ontario Regulation 17/95, section 4.

35 Revised Statutes of Ontario 1990, chapter P. 40, section 32(1).

36 See above at section 1.

37 *R. v. M.D.S. Laboratories Ltd.* (1985), 8 Ontario Appeal Cases 218 at 220 (Court of Appeal).

38 *R. v. Rao* (1984), 9 Dominion Law Reports (4th) 542 at 571 (Ontario Court Of Appeal).

See also: *R. v. Thompson* (1990), 50 Canadian Rights Reporter 1 at 21 (Supreme Court of Canada).

the necessity of follow-up counselling. Children may not go to a hospital or a hospital clinic to have these tests done if parental consent was required. Abortions are not to be performed on a person under age 16 in Ontario hospitals without the consent of a parent. Not all children have access to private clinics to perform these types of procedures. Private abortion clinics exist in very few communities. To be admitted to a hospital for treatment, homeless children had to find a "parent" to give consent. This was often an insurmountable barrier. Regulation 965 significantly limited the ability of minors to consent to their own medical care. It was also an effective barrier to medical treatment for many children under age 16. Unfortunately for these children, many hospitals still require parental consent before treatment is supplied.

Under their right to security of the person under section 7 of the Charter, competent children may have a right to direct their own treatment. The majority of the Supreme Court in *R. v. Morgentaler* (1998) held that "the constitutional right to security of the person must include some protection from state interference when a person's life or health is in danger."³⁹ If children cannot be tested or treated for sexually transmitted infections without parental consent, they can be effectively prohibited from undergoing these procedures. The deterrent effect of requiring parental consent, described above, can clearly put a child's health in danger, even where there is no immediate emergency.

In *Morgentaler*, three justices went further in their reasoning. Writing for this group, Chief Justice Dickson held that forcing a woman to carry a foetus to term, for reasons unrelated to her own priorities and aspirations, is a "profound interference with a woman's body and thus a violation of security of the person."⁴⁰ *Morgentaler* struck down a law that required a woman to get consent from an abortion committee to undergo the procedure. It is not a large leap of logic to apply this reasoning to the issue of allowing children to consent to medical treatment. Where a child has expressed wishes regarding a treatment that he or she understands, ignoring that child's priorities and aspirations and forcing them, by law, to concede to the wishes of his or her parents is clearly an interference with that child's body.

Peter Hogg is a leading authority on the Canadian Constitution. He suggests that, based on *Morgentaler*, security of the person includes some "requirement of personal autonomy" with respect to medical treatment.⁴¹ Under Chief Justice Dickson's reasons, any provision in law that deprives children from making their own health care choices is inconsistent with section 7 of the Charter and should be found to be of no force or effect. The law could only be saved by section 1 of the Charter if the limit it places on a child's security of the person can be demonstrably justified in a free and democratic society. However, as will be shown below, there are no compelling arguments against giving children the right to direct their own medical treatment.

There is also a Charter argument to be made under section 15(1), the guarantee of equal benefit and protection of the law. That section specifically lists age as a forbidden ground of discrimination. Under this section, it should be a patient's ability to understand

39 This holding was the bottom line for the five judgments of the majority. *R. v. Morgentaler* (No. 2), [1988] 1

Supreme Court Reports 30 at 90, (Justice Beetz).
40 See above at 56-57.

41 Peter W. Hogg, *Constitutional Law of Canada*, 3d ed. (Scarborough: Carswell, 1992) at 1029.

the proposed treatment, not the patient's age, which determines whether the patient has the capacity to provide valid consent. In *Re: L.D.K.*,⁴² the Ontario Provincial Court held that section 15(1) prevents government agencies from using age as a basis for excluding children from decisions about their own treatment. Under the Charter, the law should not prevent children from providing consent to treatment when they understand the nature and the risks associated with that treatment. Hospitals are not government agencies and are not subject to the Charter.⁴³ They are free to maintain policies that require parental consent for treatment of minors. Doctors in private practice are also unencumbered by the Charter. However, the provisions of the 1996 Consent Act bind both these agencies. Where a child who understands a medical procedure has expressed wishes regarding that procedure, health care providers must comply with those wishes. Physicians may only refuse to treat a minor without parental consent. However, such an action may be harmful to the health of the child.

Concerns About Minors Directing Their Own Health Care and Ontario Bill 91

Negative reactions concerning children's self-direction in securing medical treatment are rooted in two deeply held beliefs in our society. The first belief is that children do not have the ability to properly evaluate their options and make sound decisions. The second is that it is the parent's role in the family to guide and make decisions for their children. Anything that undermines that role is felt to undermine the institution of the family. However, neither of the two beliefs survive careful scrutiny. Neither justifies prohibiting minors from making decisions regarding their health care.

Are children incapable of making their own decisions? Kids Help Phone concluded that children are not inherently unable to make their own decisions, although children are often lacking in experience and information resources. When these factors are compensated for, children, especially adolescents, have few problems making rational decisions.⁴⁴ In the field of medicine, health care providers serving adolescents have not widely contested this perspective. The Windsor Teen Health Center's position on decision making capability is similar to that of Kids Help Phone.⁴⁵ In addition, many family physicians note that their pediatric patients with chronic illnesses understand their ailment better than they commonly believed. This is because those children are exposed to specialists and others who have an intimate knowledge of the condition, and the child has first-hand experience with the ailment. Many child care professionals believe that children who have good information make sound decisions. Psychological evidence supports the idea that many children can competently make their own decisions. While cognitive skills develop differently between individuals, generally it has been found that adolescents are as able as adults to make sensible decisions.⁴⁶ An Australian study found that children as young as nine years old could focus on "sensible and important reasons" in their decision making process. The study concluded that they could competently make health care decisions.⁴⁷

Given this evidence, a presumption that children can make their own decisions is a

42 *Re: L.D.K.* (1985), 48 Reports of Family Law (2d) 164 at 171 (Ontario Court of Justice (Provincial Division)).

43 See *Stoffman v. Vancouver General Hospital*, [1990] 3 Supreme Court Reports 483.

44 Kids Help Phone, 1993 Annual Report (Toronto, 1993) at 3.

45 Teen Health Centre, *Helping Teens make the Right Choice*, pamphlet.

46 See note 6 at 503.

47 V. Dharmananda, *Informed Consent To Medical Treatment: Processes, Practices and Beliefs* (Law Reform Commission of Western Australia, 1992) at 12.

logical policy choice. No one suggests that children who do not understand the nature or risks of a proposed treatment should be able to provide consent. Only where physicians believe that their patient is not competent to provide consent should they seek direction from another person. This position is the law as found in the 1996 Consent Act. The argument that children should not be able to direct their own health care because they are not able to make sound decisions is valid, but not helpful against this legislation. Children unable to make sound decisions are still not required to make them. However, family values were the basis for much of the opposition to the 1996 Consent Act and its more explicit continuation of the extension of capacity for medical consent to children.

Much of the concern expressed about providing children with a legal right to direct their own health care is based on the belief that the existence of such a right will undermine the role of parents in the family to make decisions for their children. This belief is a vestige of paternalist family values. Historically in many western societies, wives and children were property. Men made all the important decisions for the rest of the family. The law did not recognize that conflicts could exist within families.⁴⁸ There is concern that allowing a child to ignore the wishes of a parent, in favour of his or her own desires, undermines the family unit. It is a basic value for many in Canadian society that children should honour their parents. People continue to believe that an important part of the child rearing responsibilities of parents is to make important decisions for their children.⁴⁹ Doing so is a form of guidance for the child. Allowing a child the legal right to ignore a parent's wishes, even as they pertain to that child's body, would promote conflicts within families and result in the dissolution of family units.

Nonetheless, there are many reasons why the family values argument cannot justify denying competent children the right to direct their health care. A study of treatment preferences among Australian adolescents showed that most children are willing to defer to their parents' judgment, or at least consider their opinion, when major health care decisions must be made.⁵⁰ Good parents do not need legislation to force their children to consult them on their health care problems. In ideal families, there is a "level of trust and confidence between parents and children that allows a free and open discussion of any matter."⁵¹ These ideal families will not be affected if the law allowed children to direct their own health care.

The many children who do not live in ideal families need the right to consent to their health care. These children do not have the relationship with their parents that allows them to discuss sensitive health care issues with them. This situation may have developed as the result of abuse, communication problems, value differences between parent and child, or simply because of an embarrassing health problem. In all these circumstances, minors may not want to consult with their parents. Unfortunately, requirements of parental consent are not likely to force these children to consult their parents. Instead, they are likely to force the children to not get medical treatment for their health problems.

In 1996, a member of the Ontario Provincial Parliament, Mr. Klees, introduced Bill

48 See note 6 at 503.

49 See note 18 at 5419 (Mr. Klees, MPP).

50 See note 47 at 112-114.

51 See note 18 at 5421 (Elinor Caplan, MPP). Ms. Caplan worked on the drafting of the 1996 Consent Act as Minister of Health.

91, An Act to Provide for Parental Consultation Under the Health Care Consent Act, 1996.⁵² This was an attempt to amend the 1996 Consent Act to restrict the rights of minors under that Act. Bill 91 did not deny competent children the right to consent to their own health care. It merely required that before health practitioners could treat persons under the age of 16, they must make reasonable efforts to consult with at least one of the patient's parents. Bill 91 provided exceptions to this rule where the child was married, the child was seeking treatment for abuse by a parent, or the child would be abused as a result of seeking the treatment.⁵³ In an emergency, a health care provider could still provide treatment without consulting the parents.⁵⁴ Bill 91 was defeated at first reading by a vote of 42 to 34.⁵⁵ The Hansard Reports on the debate on this Bill reveal not only the reasons for the Bill's defeat, but also the importance of not limiting the legal right of children to direct their own health care.

During the debate over Bill 91, several MPPs stood up to argue for defeat of the Bill. They argued that the proposed amendments to the 1996 Consent Act would not promote stability in the family unit, but would discourage children from seeking medical care. The opposition did not believe that health care providers would be consistently able to detect or predict abuse. The Bill would not promote family stability because stable families would not need its provisions. Where there were problems in the family, even minor ones, the proposed amendments would not protect the family; they would only discourage children from getting medical help. MPPs were particular concerned that they should not discourage minors from being tested and treated for sexually transmitted infections. The legislative reports reveal that the Hospital for Sick Children, the Windsor Teen Health Centre and the Yonge Street Mission all opposed Bill 91 for these reasons.

An absence of legal restrictions on children's ability to consent to health care is insufficient to address the concerns mentioned in the Ontario Legislature.

There is also a need for a legal presumption that children are able to direct their own health care. Laws that do not create this presumption, such as section 17 of the Infants Act of British Columbia,⁵⁶ do not adequately protect the rights of children to direct treatment that they understand. Children do not have the same access to legal resources that their parents do. They cannot direct their own litigation. They cannot afford to hire lawyers. It is still difficult for them to have their voice heard in court. Requiring children to legally prove that they have capacity to make treatment decisions is the same as denying them that capacity. The legal presumption of capacity allows children, who understand the decision they are making, to have their wishes respected.

The Impact of the Current Law on Minors

The law in Ontario is simple. Where a minor understands the nature of a proposed treatment and the risks involved in both undergoing and refusing that treatment, he or she is entitled to give valid consent or refusal to that treatment. Children can give consent to undergo medical procedures that they do understand, even if there are other treatments that they do not understand. If a child has the requisite level of understanding, that child's

52 1st session, 36th Legislature, Ontario, 1996.

53 See above at section 1.

54 1996 Consent Act, section 25(2).

55 See note 18 at 5426.

56 Under the British Columbia law, a health care provider cannot respect a child's treatment wishes unless that provider has been satisfied that the child understand the treatment. This places the onus on the child to demonstrate that understanding. See note 17.

wishes must be respected over those of the parents. Further, health care providers cannot incur liability for obeying the wishes of a child that they believe has provided valid consent or refusal. There is no legal reason to prevent a doctor from following the instructions of children who fully understand the instructions that they have given. This law seems to solve the specific problems of the children mentioned in this paper.

In the example I referred to earlier, Mark had clearly expressed his wish to have his treatment continued and those wishes should have been immediately respected. At the time I asked what his wishes were, the young athlete was fully oriented as to person, time and place. In other words, despite being lethargic, he was fully conscious. He understood that he was in an ambulance and that a paramedic was treating him. He also understood that the proposed continuation of his treatment was that he be driven to the hospital in an ambulance. The main risk involved in that treatment was the remote possibility of a motor vehicle accident involving the ambulance. It is a safe assumption that an 11-year-old could understand the concept of an accident. These facts provide no basis on which to rebut the presumption of capacity. With that level of understanding, Mark was free to direct me to take him to the hospital. The boy did in fact provide those instructions. I had no reason to disbelieve that I had received valid consent to treatment. As a health care provider, I was free to follow Mark's directions without fear of liability for respecting his wishes. The correct legal response to his father's continued protests would have been to close the back doors and take Mark to the hospital immediately.

Minors who understand that they need testing for sexually transmitted infections are likely mature enough to understand the tests. There is no reason, at law, for a doctor to refuse a request for these tests. In fact, allowing children to have access to these tests without parental consultation was one reason the Ontario Legislature enacted the 1996 Consent Act. Every clinic in Ontario should be a "hassle-free" clinic for teenagers.

Although the law is often on the side of all children consenting to treatment, it is often difficult for children to exercise their rights under that law. The law exists to allow children who understand a medical procedure to consent to it. However, children are still rarely able to have their medical directions respected. This is especially true where their wishes conflict with those of their parents. Very few children or health care providers know what the law is with respect to the ability of minors to consent to health care. Currently, the problem is more educational than legal.

Doctor's and Children's Understanding of the Law of Consent

Two studies have looked at how doctors and children understand the law concerning a minor's ability to consent to health care. The University of Toronto conducted one of these studies in 1979 and 1980.⁵⁷ The Law Reform Commission of Western Australia conducted the other in 1992.⁵⁸ The law for both studies was essentially the common law rules for consent of minors as described above. Both studies concluded that there was a general misunderstanding of the law. Both doctors and children had almost no knowledge that the law allowed minors who understood the nature and risks of a procedure to provide

57 Katherine Catton, Wendy Graham and Eater Koulack, *Doctor's Understanding of and Practices Regarding the Law of Minors' Medical Consent: A Pilot Study* (Toronto: University of Toronto, 1979). Also see note 3 above.

58 See note 47.

a valid consent to that procedure.

In the Australian study, none of the physicians surveyed believed that minors could make the ultimate decision over their treatment. A large majority (73.3 per cent) felt that the decision in such cases should be made by the parent, the minor, and their physician. Where a minor's expressed wishes directly contradicted those of a parent, 53.3 per cent of responding doctors would try to convince the parent to accept the child's wishes, but only if they thought the child had made the correct choice.⁵⁹ None of the physicians tested their young patients to determine if they were capable of making their own treatment decisions.⁶⁰

The Ontario study showed that only seven per cent of physicians understand the law of consent as it relates to minors. Most respondents to the study believed that age, living status and the nature of the presented problem determined whether a minor could give valid consent.⁶¹ However, most of the doctors surveyed believed that the law should be what it in fact was. They wanted a law that allowed them to provide treatment to minors who understood the nature, risks and benefits of the proposed treatment. The doctors felt that this determination should be made on an individual, case-by-case, basis.⁶² This was the law at the time of the study. Where the doctors did know the law, they were still reluctant to recognize the validity of a minor's consent. This apprehension grew out of fears of being held liable if they treated a child against the wishes of a parent.⁶³ Protection from this type of liability was a new addition to the law in the 1996 Consent Act.

The beliefs of minors in both studies mirrored those of the physicians. In Australia, 100 per cent of the responding minors were willing to concede to their parent's wishes regarding treatment.⁶⁴ However, 46.7 per cent of the responding minors expected doctors to follow the instructions of their parents when they contradicted their own. An additional third of the respondents did not know whose wishes would be respected.⁶⁵ In Ontario, only 10 per cent of responding minors could correctly state the law.⁶⁶ Most thought that they could not provide a valid consent until age 16.⁶⁷ For 62 per cent of the responding children, this incorrect belief caused them to hesitate before seeking treatment for a medical problem. They did not want their parents consulted or were afraid that such a consultation would be embarrassing.⁶⁸

Clearly, neither health care providers nor minor patients understand the law as it relates to the validity of medical consent of minors. In order for children to take full advantage of their legal right to direct their health care, both they and their treatment providers will have to be educated regarding the state of the law. Informing all health care workers of the reasons for allowing children to direct their own treatment will be particularly important. It will also be important to inform those professionals that they cannot be held liable for respecting the wishes of minors where there are no apparent reasons to doubt the patient's capacity to consent. The Australian and Ontario studies show that without this education, the health care wishes of children will not be respected. The ruling in *S.H.* also suggests that the courts are not aware of the importance of allowing children to consent to their own medical treatment. In that case there was evidence that the child did fully

59 See above at 115-116.

60 See above at 112.

61 See note 57 at 58.

62 See above at 64.

63 See above at 65.

64 See note 47 at 112.

65 See above at 117.

66 Note that this is

greater than the

percentage of doctors

(only seven per cent).

See note 57 at 62.

67 See above at 64.

68 See above at 65.

understand the nature of the treatment she was rejecting and what the consequences of that rejection were.⁶⁹ However, the Court felt that the minor patient's wishes were a sufficiently important consideration to stop the treatment. This ruling had undesirable consequences for the patient. She was forced to flee the country and deplete all her family's money to get the treatment she desired.⁷⁰ It should be noted that in *Re: L.D.K.*,⁷¹ an earlier case with identical facts save that the child was a year younger, the court decided to follow the wishes of the child. The court found that refusing the minor patient's wishes would be harmful to her.⁷² Further, it found that ignoring her clearly stated wishes, solely because of her age, violated her section 15(1) Charter right to equality.⁷³ The 1996 Consent Act will have no effect if both health care providers and minors are not aware of the rights it gives to children to direct their own treatment. The courts must also realize the importance of enforcing those rights.

Conclusion

Children like Mark are fully able to direct their own treatment. This is true even when their wishes contradict those of their parents. The 1996 Consent Act allows health care workers to assume that children can provide valid consent or refusal to treatment. Children are presumed to be able to understand both the nature of the proposed treatment and the risks of consenting or refusing it. Only where a physician has reasonable grounds to believe that a child lacks that understanding is deference given to the wishes of that child's parents. The protection from liability for abiding by a child's wishes, where it is believed that the child has capacity to make health care decisions, allows health care workers to respect those wishes without fear of legal persecution. If a child understands the nature of the proposed treatment and the possible consequences of consenting or refusing it, that child's wishes must be respected.

Allowing competent children to make their own health care decisions is important for several reasons. First, children are free to seek treatment for all their problems without fear that their parents will be informed. Where there are requirements of parental involvement for treatment, children tend to avoid seeking that treatment. Such requirements lead to children not getting treatment for sexually transmitted infections, pregnancy, and drug addictions. Second, children are free to seek treatment for abuse they have suffered without fear that their abuser will have to be consulted. Lastly, and most importantly, it is recognized that children have an essential human right to have control over their own bodies.

Clearly, neither children nor health care providers understand the law of medical consent as it relates to minors. Both groups believe that the law is more restrictive on the rights of children than it actually is. Education programs are needed to inform children and health care providers of the state of the law in Ontario. Additional education is needed for the health care providers to ensure that they understand both the importance of allowing children to direct their own treatment and that they are not liable for respecting the wishes

69 See note 29 at 97.

70 Catherine Dunphy, "They Must Have Cared a Lot to Fight Me So Hard" (12 April, 1998) *The Toronto Star* F5.

71 See note 42.

72 See above at 11-12.

73 See above at 16-17.

of a minor they believe is competent. This education is essential for ensuring that the rights of children to direct their own health care are respected.