

Fundamentally, this paper is about a boy named Mark and the difficulties he had getting medical help when he really needed it. His situation made me aware of the legal problems of many kids in this country. After meeting Mark, I made a vow to find a solution to his problem. When someone asks me why I decided to go to law school, I tell them Mark's story.

I met Mark on a hot July day. At the time, I was working as an ambulance attendant. On that particular day, I had been assigned to provide emergency coverage for a children's triathlon. This was a new event and we had not yet learned to implement proactive measures to prevent injuries to the athletes. Mark was one of the competitors at the event. He was eleven 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. Even from a distance, we could hear his parent 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 did. The young athlete staggered across and promptly fell to the ground, face first. When he made no further attempts to move, I ran over. His only reply to my questions was to cover my boots with his "used" lunch.

One of the skills an ambulance attendant develops with experience is the ability to tell, on sight, when someone is really sick. After I turned him over, I realized that Mark was probably one of the sickest kids I had ever seen. His skin was red and dry. His body was limp. His

eyes were cloudy. I picked up the small body and ran to the ambulance. One of the race officials read the competitor number off one of Mark's legs and ran off to find the boy's parents.

This turned out to be a mistake.

In the back of the ambulance, I quickly doused Mark with cold water. I noted that his pulse was faster than I would have expected. His blood pressure was low. However, my biggest concern was his breathing. I noted that his breaths were neither deep, nor very frequent.

I decided that Mark needed my assistance to breathe. Ambulance attendants do not use mouth-to-mouth because of the fear of spreading infections. Instead, they use a device called a "bag-valve-mask." Essentially, this is a bag with an oxygen supply attached to one end and a face mask attached to the other. When the bag is squeezed, oxygen is forced into the mouth of the patient. Mark started to come around when I assisted his breathing in this way. 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 screamed. He then 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 . . . Please." Mark's father countered with another order to me to stop treatment.

The training for ambulance attendants is fairly clear regarding medical consent. The

Emergency Health Services Branch of the Ministry of Health interpretation of the law is that for a person to give consent, they must be 18 years old, although consideration can be given to the wishes of a 16-year-old. The only exception to this rule is where the minor is married. In all other cases, the wishes of the parents, where ascertained, must be respected.¹ According to this training I was required to stop treatment and turn Mark over to his father.

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 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

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

treatment.

This paper will demonstrate the need for kids 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 kids 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, or even necessarily the most harmful, expression of this problem. Many kids avoid seeking treatment for their medical problems when they believe that their parents must become involved. This may be the result of a conflict of values with their parents, or it may just be the result of fear of embarrassment. Either way, 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 whether to provide that consent. These conflicts can be very traumatic for a child. The child's world has evolved into one of new uncertainty. That world has suddenly come into conflict with that of the parents. Until that point, the child may have thought that there was only "one world."

Older children and 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. It is even more uncomfortable for them to discuss medical

problems they may be having. They are hesitant to discuss these problems with their parents or with a health care provider in the presence of their parents.² Kids may avoid seeking treatment for their ailments if they believe that treatment would require either parental consent or notification.³ This situation develops even where there are no conflicts in values between parent and child.

The issues that are the most important in children's health are the ones that have the largest possibility of instigating conflict between a parent and child. For kids, the most important medical questions are those relating to birth control, pregnancy, abortion, sexually transmitted infections, substance abuse and addiction, nutrition and psychological problems.⁴ These are sensitive issues. They are embarrassing for a kid to talk about and can cause conflicts in a child's family. Kids are reluctant to seek treatment if their parents must become involved out "of fear of parental disapproval or even retribution."⁵

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

³Katherine Catton, Valerie Farrer, 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*Ibid.* at 11, 15-16.

⁵*Ibid.* at 12.

Kids are not as innocent as society often idealizes them as being. 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 21, 1993, 1,167 American teenagers had contracted AIDS. Between 24 and 30 percent of gonorrhea cases are found among teenagers. Ninety percent of high school students have used alcohol. Forty percent have used marijuana and at least 10 percent have used cocaine.⁶ Medical problems result from these behaviours. However, these problems are subjects that minors are loathe to discuss with their parents.

Kids 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 a minor 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 STD's? By this I mean without going to my normal doctors office.

Response (2 of 2) 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 kids help phone has tones. [tonnes?]⁷

⁶William 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<http://forums.sympatico.ca/forum.cgi?khp-13@^98@.ee6bd6a> on March 16, 1997.

This example shows how important it is to kids to not involve their parents in sensitive health care decisions. It also shows how difficult this can be. Kids 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 their regular physician out of fear that their parents will find out.⁸ This is especially the case if the youth is gay or lesbian.⁹ Given the rates of infection for these diseases among minors, parental consent requirements are effectively a threat to the health of minors.

There is no stronger argument against requiring parental consent for medical care than the effects such a requirement would have on abused children. Suggesting that an abused child should have to seek the permission of their abuser to get treatment for the abuse they have suffered is ludicrous. The following postings from the Kids Help Phone Web Site Discussion Forum on Birth Control perfectly 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: (4 of 11) by "pk":
it's ok people i forced a miscarriage on myself so nobody has to know now. Thanks anyway. :)¹⁰

When kids are forced to circumvent parental consent to avoid a conflict, the results can be

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

⁹*Supra* note 6 at 496.

¹⁰[Http://forums.sympatico.ca/forum.cgi?khp-7@1146@.ee6bb24/0](http://forums.sympatico.ca/forum.cgi?khp-7@1146@.ee6bb24/0) on March 16, 1997.

devastating.

Many kids leave home to avoid abusive situations. For kids living on the street, getting parental consent for a medical procedure is practically impossible. The requirement denies street youth access to health care.

Conflicts between parent and child are not the only ones that can make it difficult for a minor to receive medical care requiring parental consent. Disputes between parents can have equally devastating results. The “best interests of the child” are supposed to be a central objective in family disputes. However, when a dispute escalates, the child often becomes no more than a pawn in a gambit to extract revenge. Getting clear parental consent for medical treatment in such a situation can be difficult.¹¹ In those situations, parents may dispute each other’s capacity to provide consent, or they may express opposing wishes regarding treatment for their child. The health care provider may not be able to get valid instructions from anyone.

The Law in Ontario

Ontario has new legislation addressing issues of medical consent. The *Health Care Consent Act, 1996*¹² 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 their own decision regarding that treatment. Further, s. 4(2) states that a “person” is presumed able to make their own decisions regarding treatment. Under ss. 4(3) and

¹¹*Supra* note 6 at 504.

¹²S.O. 1996, c. 2, [hereinafter the *1996 Consent Act*].

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*.¹³ In *Re "Baby R,"*¹⁴ the court specifically held that the definition included children.¹⁵ The term "person" in the *Canadian Charter of Rights and Freedoms*¹⁶ was explicitly held to include children under age 16 in *R. v. J.(R.)*.¹⁷ At law, children are persons. They are presumed to be able to consent to their own medical treatment under 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 by reviewing the records of the Ontario Legislature. When the act was debated, the question of whether children should be given this right was

¹³[1991] 1 S.C.R. 489 at 503. See also the decision of Robins J., in *Dehler v. Ottawa Civic Hospital* (1979), 25 O.R. (2d) 748 at 757 (H.C.).

¹⁴(1988), 15 R.F.L. (3d) 225 (B.C.C.A.).

¹⁵*Ibid.* at 231.

¹⁶Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11 [hereinafter *Charter*].

¹⁷(1982), 1 C.R.R. 202 at 204 (Ont. Prov. Ct.).

discussed. The Ontario Legislature supported the proposition.¹⁸ The intent of Parliament in enacting the *1996 Consent Act* was clearly to allow children to consent to their own medical treatment. The expressed intentions of Parliament should be respected when interpreting legislation.

¹⁸Ontario, Legislative Assembly of Ontario, *Official Report of Debates (Hansard)*, No.130 (28 November 1996) at 5420.

Despite concerns expressed 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 the leading case in this area. One of the issues to be decided in that case was whether a 20-year-old minor could consent to medical treatment. Mr. Justice Addy 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. A child can direct their own treatment if they can appreciate fully the nature and consequences of the procedures in question.²⁰ According to this ruling, minors always had the right to consent or refuse treatment that they understood.

The Ontario Legislature entrenched the rule in *Johnston* in the *Consent to Treatment Act, 1992*,²¹ the predecessor to the *1992 Consent Act*. Section 6(1) of the *1992 Act* recognized that a “person” could consent to medical treatment if they understood the “nature” and “possible consequences” of the proposed procedures. Under the old act, children could consent to treatment that they understood. It is ludicrous to suggest that because a child understands a simple procedure, they have the authority to give consent for all procedures related to their 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.

Both the *1996 Consent Act* and the *1992 Act* recognize that capacity to consent to medical

¹⁹[1971] 2 O.R. 103 (H.C.) (QL) [hereinafter *Johnston* cited to QL].

²⁰*Ibid.* at 14-15.

²¹S.O. 1992, c. 31 [hereinafter the *1992 Act*].

treatment depends on both the ability of the patient to understand the treatment proposed and also when the treatment is proposed. Section 15(1) of the *1996 Consent Act* recognizes that a person can consent to some procedures, but not others. A child can consent to simple procedures that they understand, such as an ambulance ride, but not to others that they do not, such as surgical treatment for a brain tumor. Section 6(2) of the *1992 Act* was essentially the same as Section 15(1) of the *1996 Consent Act*.

Section 15(2) of the *1996 Consent Act* and s.6(3) of the *1992 Act* recognize 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 more treatments. A six-year-old child may not understand a proposed treatment. However, a 12-year-old child may have developed sufficient understanding of the same procedure to direct their own 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 will apply to children suffering from chronic diseases. At age six, they may not understand the treatment they are receiving. As they grow older, the child may develop a greater understanding of their disease and its treatment. When a child understands both the nature of the treatment and the risks associated with continuing and ending it, they are able to make their own decisions regarding that

treatment. A young cancer patient may not understand what is going on when treatment starts. However, during that course of treatment, the patient may develop sufficient understanding to decide whether to continue the treatment. The old act did not specifically give a person the right to make their own decisions regarding treatment after someone else provided the initial consent.

The *1996 Consent Act* differs from the previous law in an 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 in the United States, a minor is presumed to not be competent to make their own treatment decisions.²² The only exceptions to this rule are where a child is married, legally emancipated from their parents, or has 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 they have sufficient understanding of the proposed procedure to allow them 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, a minor must be able to prove their understanding of the proposed treatment before their wishes can be respected.

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

²³*Ibid.* at 70.

²⁴*Ibid.* at 73-74.

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 wished to refuse life saving treatment for his leukemia because it involved blood transfusions. 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 a minor 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, Mister Justice Ryan concurred in the result, but for distinct reasons. 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, Mister 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.

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

²⁵(1994), 4 R.F.L. 321 at para 25 (QL) [hereinafter *Walker* cited to QL].

²⁶*Ibid.* at para 31, 42.

²⁷*Ibid.* at para 25, 29.

²⁸*Ibid.* at para 66-70.

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. Kids have many more hurdles to jump to have their views heard by a court.²⁹ However, s. 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.

²⁹In Ontario, a minor must have an adult litigation guardian to commence an action. Ontario, Rules of Civil Procedure, r. 7.04(1).

Before being revoked in 1996, s. 26 of Ontario Regulation 965³⁰, made pursuant to the *Public Hospitals Act*,³¹ was a significant limit on the ability for kids to direct their own treatment.

It made it impossible for kids 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 sixteen 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 publically funded hospitals including all other “places” operated by the hospital for the treatment of the sick and injured.³² 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.”³³ Presumably hospital-run clinics were subject to Regulation 965. As the word “place” has also been interpreted to include vehicles,³⁴ 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 s. 26 of Regulation 965 was, and continues to be, devastating for kids seeking medical treatment without involving their parents. They cannot go to a hospital or a

³⁰R.R.O. 1990, 1990, Reg. 965, s. 26, as rep. by O. Reg. 17/95, s.4.

³¹R.S.O. 1990, c. P. 40, s. 32(1).

³²*Ibid.* at s.1.

³³*R. v. M.D.S. Laboratories Ltd.*(1985), 8 O.A.C. 218 at 220 (C.A.).

³⁴*R. v. Rao* (1984), 9 D.L.R. (4th) 542 at 571 (Ont. C.A.). See also: *R. v. Thompson* (1990), 50 C.R.R. 1 at 21 (S.C.C.).

hospital clinic for many procedures. Testing for Sexually Transmitted Diseases usually requires written consent. Testing for AIDS always requires written consent because of the necessity of follow-up counseling. Kids would 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 kids 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, street kids had to find a “parent” to give consent. This was often an insurmountable barrier. Regulation 965 was a very significant limit on the ability of minors to consent to their own medical care. It was also effectively a barrier to medical treatment for many kids under age 16. Unfortunately for these kids, many hospitals still require parental consent to treat children under the age of 16.

Under their right to security of the person under s. 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*, 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.”³⁵ If a child cannot be tested or treated for Sexually Transmitted Infections or drug abuse or undergo an abortion 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 kid’s health in danger, even where there is no immediate emergency.

³⁵This holding was the bottom line for the 5 judgments of the majority. *R. v. Morgentaler* (No. 2), [1988] 1 S.C.R. 30 at 90 (Beetz, J.) [hereinafter *Morgentaler* cited to S.C.R.].

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.”³⁶ *Morgentaler* struck down a law that required a woman to get consent from an abortion committee to undergo the procedure. It 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 they understand, ignoring that child’s priorities and aspirations and forcing them, by law, to concede to the wishes of their 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.³⁷ Under Dickson’s reasons, any provision in law that deprives a child from making their own health care choices is inconsistent with s. 7 of the *Charter* and should be found to be of no force or effect. The law could only be saved by s. 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.

³⁶*Ibid.* at 56-57.

³⁷Peter W. Hogg, *Constitutional Law of Canada*, 3d ed. (Scarborough: Carswell, 1992) at 1029.

Hospitals are not government agencies and are not subject to the *Charter*.³⁸ 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. A doctor may only refuse to treat a minor without parental consent. However, such an action would probably be harmful to the health of the child. Doctors should be loath to make such a decision because of the harm it might cause.

Concerns About Minors Directing Their Own Health Care

and Ontario Bill 91 The reaction of many adults, especially parents, to learning that the law allows kids to direct their own health care is one of surprise and disapproval. This reaction is 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 good 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. These beliefs are raised to argue against giving minors the legal ability to make treatment decisions. However, neither of the two beliefs survives careful scrutiny. Neither justifies prohibiting minors from making decisions regarding their health care.

³⁸See *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483.

The position of Kids Help Phone, after talking with thousands of Canadian children and teenagers, is that kids are not inherently unable to make their own decisions. Kids are lacking in experience and information resources. When these factors are compensated for, children, especially adolescents, have few problems making rational decisions.³⁹ 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.⁴⁰ In addition many family physicians note that their pediatric patients with chronic illnesses understand their ailment better than they do. This is because those children are exposed to specialists and others who have an intimate knowledge of the condition and they have first hand experience with the ailment. Many child care professionals believe that children who have good information make good 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 good decisions.⁴¹ 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.⁴²

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

³⁹Kids Help Phone, *1993 Annual Report* (Toronto, 1993) at 3.

⁴⁰Teen Health Centre, *Helping Teens make the Right Choice*, pamphlet.

⁴¹*Supra* note 6 at 503.

⁴²V Dharmananda, *Informed Consent To Medical Treatment: Processes, Practices and Beliefs* (Law Reform Commission of Western Australia, 1992) at 12.

policy choice. No one suggests that kids who do not understand the nature or risks of a proposed treatment should be able to provide consent. Only where doctors 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 good decisions is invalid against this legislation. Children who are unable to make good 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 over providing children with a legal right to direct their own health care is based in the belief that the existence of such a right would undermine the role of parents in the family to make decisions for their children. This belief is the vestige of old paternalist family values. Historically, 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.⁴³ There is concern that allowing a child to ignore the wishes of a parent, in favour of their own desires, undermines the family unit. It is a basic value 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.⁴⁴ Doing so is a form of guidance for the child. Allowing a child the legal right to ignore a parent's

⁴³*Supra* note 6 at 501.

⁴⁴*Supra* note 17 at 5419 (Mr. Klees, MPP).

wishes, even as they pertain to that child's body, would promote conflicts within families and result in the dissolution of family units.

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 kids are willing to defer to their parents judgment, or at least consider their opinion, when major health care decisions must be made.⁴⁵ Good parents do not need legislation to force their kids 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."⁴⁶ 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 kids 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 the existence 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 kids to consult their parents. Instead, they are likely to force the kids to not get medical treatment for their health problems.

⁴⁵*Supra* note 41 at 112-114.

⁴⁶*Supra* note 17 at 5421 (Elinor Caplan, MPP). Ms. Caplan worked on the drafting of the 1996 *Consent Act* as Minister of Health.

In 1996, Mr. Klees, MPP, introduced Bill 91, *An Act to Provide for Parental Consultation Under the Health Care Consent Act, 1996*.⁴⁷ The act did not deny competent children the right to consent to their own health care. It merely required that before a 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. The amendment 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.⁴⁸ In an emergency, a health care provider could still provide treatment without consulting the parents.⁴⁹ The bill was defeated at first reading by a vote of 34 to 42.⁵⁰ The Hansard Reports on the debate on this bill reveal not only the reasons why the bill was defeated, 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 the defeat of the bill. They all argued that the proposed amendments to the *1996 Consent Act* would not promote stability in the family unit but would discourage kids 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

⁴⁷1st sess., 36th Leg., Ontario, 1996.

⁴⁸*Ibid.* at s. 1.

⁴⁹*Supra* note 11 at s. 25(2).

⁵⁰*Supra* note 17 at 5426.

protect the family, they would only discourage kids 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. If the mere requirement of parental consultation would result in all these problems, required parental consent would result in many more. No legal restriction on the ability of competent minors to consent to their own treatment can still be justified in our society.

An absence of legal restrictions on children's ability to consent to health care is insufficient to address the concerns mention in the Ontario Legislature. There is also a need for a legal presumption that children are able to direct their own health care. Kids 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 kids to have their voice heard in court. Requiring a child 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 kids, 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, they are 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 they do not understand. If a child has the requisite level of understanding, their 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 reason at law 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 kids mentioned in this paper.

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 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 only 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.

The writer wanting to get tested for STIs should have no problem getting the tests without being hassled. Minors who understand that they need testing for such infections are

probably mature enough to understand the tests themselves. There is no reason at law for a doctor to refuse this request. In fact, allowing children to have access to this type of procedure without parental consultation was one reason the Ontario Legislature enacted the *1996 Consent Act*. Further, there is no reason for the doctor to fear legal repercussions for providing this service to the kid who posted the question on the Kids Help Phone Web Site. Every clinic in Ontario should be a “hassle-free” clinic for teenagers.

In Ontario, “pk” would be permitted to undergo the abortion, and any surrounding counseling, without involving her parents. Her posting showed that she understood both what an abortion is and what some risks of that procedure are. It was the intent of the Ontario Legislature in passing the *1996 Consent Act* to allow children like “pk” to receive treatment for abuse they have suffered without requiring the consent of the abuse. A hospital or clinic should accept her consent as valid and could perform the abortion, without fear of liability for respecting their young patient’s witness. There would be no state intrusion into her life if “pk” did not tell anyone involved in her treatment who the father was. This would give her the opportunity to fully consider her options on how to respond to the abuse without the stress of pregnancy.

Unfortunately for “pk,” a hospital may be reluctant to perform an abortion on someone so young without parental consent. Many hospitals have such a policy. Health care providers may not realize that “pk” can provide a valid consent to the procedure. Alternatively, they may not realize that the importance of not involving the girl’s parents. “pk” may need an effective advocate to convince the hospital to allow her to exercise her legal rights in this matter. In any event, “pk” should know that there was no legal reason for to take the drastic measures that she

took.

Although the law was on the side of all three children in these examples, not one of them was able to fully 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 kids 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 1980⁵¹. The Law Reform Commission of Western Australia conducted the other in 1992.⁵² 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 a valid consent to that procedure.

In the Australian study, none of the physicians surveyed believed that minors could make

⁵¹Katherine Catton, Wendy Graham & Eater Koulack, *Doctor's Understanding of and Practices Regarding the Law of Minors' Medical Consent: A Pilot Study* (Toronto: University of Toronto, 1979). Study continued at *Supra* note 3.

⁵²*Supra* at note 41.

the ultimate decision over their treatment. A large majority (73.3%) 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 % 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.⁵³ None of the physicians tested their young patients to determine if they were capable of making their own treatment decisions.⁵⁴

⁵³*Supra* note 41 at 115-116.

⁵⁴*Ibid.* at 112.

The Ontario study showed that only 7 percent of doctors understand the law of consent as it relates to minors. Most respondents to the study believed that age, living status and nature of the presenting problem determined whether a minor could give valid consent.⁵⁵ 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.⁵⁶ 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.⁵⁷ Protection from this type of liability was a new addition to the law in the *1996 Consent Act*.

⁵⁵*Supra* note 50 at 58.

⁵⁶*Ibid.* at 64.

⁵⁷*Ibid.* at 65.

The beliefs of minors in both studies mirrored those of the physicians. In Australia, 100% of the responding minors were willing to concede their parent's wishes regarding treatment.⁵⁸ However, 46.7% 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.⁵⁹ In Ontario, only 10 percent of responding minors could correctly state the law.⁶⁰ Most thought that they could not provide a valid consent until age 16.⁶¹ For 62 percent 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.⁶²

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 kids 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

⁵⁸*Supra* note 41 at 112.

⁵⁹*Ibid.* at 117.

⁶⁰Note that this greater than the percentage of doctors (only 7 percent). *Supra* note 50 at 62.

⁶¹*Ibid.* At 64.

⁶²*Ibid.* at 65.

and Ontario studies show that without this education, the health care wishes of kids will not be respected. 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.

Conclusion:

Kids 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 kids 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 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 actually respected.

This paper was about Mark. His situation alerted me to the problems kids can have directing their own health care when their wishes conflict with those of their parents. It is reassuring to know that kids like Mark are able to have their health care wishes respected. However, the law pertaining to minors' consent to health care is badly misunderstood. For Mark and other kids who find themselves in similar situations, the law in Ontario bears restating again: A child is presumed to be able to understand both the nature of a medical treatment and the risks involved in both consenting and refusing that treatment. Unless there are reasonable grounds on which to rebut that presumption, the expressed health care wishes of a child **MUST** be followed.

A girl named "Casey" responded immediately to "pk"'s posting calling for help. Her advice was as follows:

You should talk to someone you trust or call the kids help phone. But now you have to make a decision based on what you believe in - you can keep the baby, you can have the

baby and give it away or you can have an abortion. But it has to be YOUR decision.⁶³

In Ontario, it is.

⁶³*Supra* note 9.

Bibliography:

Legislation:

Bill 91, *An Act to Provide for Parental Consultation Under the Health Care Consent Act, 1996*, 1st sess., 36th Leg., Ontario, 1996.

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

Consent to Treatment Act, S. O. 1992, c.31.

Health Care Consent Act, 1996, S.O. 1996, c.2.

Ontario, Rules of Civil Procedure, r. 704(l).

Public Hospitals Act, R. S.O. 1990, c. P. 40.

Reg. 965, R.R.O. 1990, s. 26 as rep. by O. Reg 17/95, s.4.

Jurisprudence:

Dehler v. Ottawa Civic Hospital (1979), 25 O.R. (2d) 748 (H.C.).

Johnston v. Wellesley Hospital et al., [1971] 2 O.R. 103 (H.C.) (QL).

R. v. J (R.) (1982), 1 C.R.R. 202 (Ont. Prov. Ct.).

R. v. M.D.S. Laboratories Ltd (1985), 8 O.A.C. 218 (C.A.).

R. v. Morgentaler (No. 2), [1988] 1 S.C.R. 30.

R. v. Sullivan [1991] 1 S.C.R. 489.

R. v. Rao (1984), 9 D.L.R. (4th) 542 (Ont. C. A.).

R. v. Thompson (1990), 50 C.R.R. 1 (S.C.C.).

Re: "Baby R, " (1988), 15 R.F.L. (3d) 225 (B.C.C.A.).

Stoffman v. Vancouver General Hospital, [1990] 3 S.C. R. 483.

Walker v. Region 2 Hospital Corp. (1994) 4 R. F. L. 321 (QL).

Secondary Materials:

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.

Alexander Morgan Capron, "The Competence of Children as Self-Deciders in Biomedical Interventions" in Willard Gaylin & Ruth Macklin, eds., *Who Speaks for the Child: The Problems of Proxy Consent* (New York: Plenum Press, 1982).

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

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

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

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

Kids Help Phone, *1993 Annual Report* (Toronto, 1993).

Kids Help Phone Web Site, <http://kidshelp.sympatico.ca>.

Ontario, Legislative Assembly of Ontario, *Official Report of Debates (Hansard)*, No. 130 (28 November 1996).

Ontario Ministry Of Health, *Ambulance and Emergency Care Program: Legal and Ethical Issues* (Thunderbay: Confederation College, 1990).

Joseph E. Simon & Aron T. Goldberg, *Prehospital Pediatric Life Support* (St. Louise: C. V. Mosby, 1989).

Teen Health Centre (Windsor), *Helping Teens Make the Right Choice*, pamphlet.