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LIFE IN THE BALANCE: SUPREME COURT OF CANADA WEIGHS THE RIGHTS OF MATURE ADOLESCENTS TO REFUSE MEDICAL TREATMENT

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A. INTRODUCTION

On June 26, 2009, the Supreme Court of Canada upheld Manitoba legislation under which a child was given a court ordered blood transfusion contrary to her religious beliefs (see *A.C. v. Manitoba (Director Child and Family Services),* 2009 SCC 30).

This case is less about religious freedom and more about the weight to be given a child's refusal of medical treatment when she is under the age of sixteen years, has the "capacity" to make medical decisions, and is facing imminent and serious danger to her health or life. The focus of this case is on mature adolescents, not young children, and is in the context of children found in need of protection under provincial child welfare legislation.

Six of the seven Judges hearing the case upheld the Manitoba legislation but wrote two separate sets of reasons. Four of the Judges decided that the statutory test of "best interests" of the child must be interpreted to include the common law concept of the "mature minor's" developing autonomy interest. According to the majority, the more a court is satisfied that the child is capable of mature independent judgment, the more determinative are the views of the child. Two other Judges held that the wishes of the child were to be a

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factor in determining the best interests of the child but not given the potentially determinative weight accorded by the majority.

The dissenting Judgment of one Judge would have accorded full weight to the wishes of the child once she was found to have capacity, irrespective of whether her wishes accorded with her best interests in the view of the court or her physicians.

All three written reasons clearly affirmed that the wishes of competent adults to refuse treatment, including life saving treatment, must be respected irrespective of their best interests, their doctors' opinion or religious motives. This legal principle predates the *Charter of Human Rights and Freedoms* (the "*Charter*") but is strongly reinforced by the right to security of the person in section 7 of the *Charter.*

B. BACKGROUND

1. Manitoba Legislation

The two sections of the Manitoba *Child and Family Services Act* (the "*Act*") that were challenged in this case under the *Charter* were section 25(8), by which a court may authorize medical treatment that it considers is in the best interests of a child, and section 25 (9), which gives the wishes of a child 16 years of age or older presumptive weight unless it is shown that the child does not understand the nature or consequences of the treatment. There is no such presumption for a child under sixteen (16) years of age.

Section 2(1) of the Act provides that in determining the "best interests" of a child, all relevant factors shall be considered, including the "mental, emotional, physical, and educational needs of the child and the appropriate care or treatment or both, to meet such needs"; "the child's mental, emotional and physical stage of development"; "the views and preferences of the child where they can be reasonably ascertained" and "the child's cultural, linguistic, racial and religious heritage."

Other pertinent sections of the *Act* were section 2(2), which requires a child over 12 years of age to be given notice of any proceedings under the Act and an opportunity to make his or her views known to the decision maker, and section 2(3), which allows the views of younger children to be taken into

account if the Judge is satisfied that they are able to understand the nature of proceedings and that it would not be harmful to the child.

2. Facts

The child, referred to as A.C., a devout Jehovah's Witness, was 14 years, 10 months old when she was admitted to hospital. Some months prior to her admission to hospital she had signed an advance medical directive containing her instructions not to be given blood under any circumstances because of her religious beliefs.

The child suffered internal bleeding caused by Crohn's disease. She refused to accept a blood transfusion recommended by her doctor who was of the opinion that the bleeding posed a serious risk to her health and perhaps her life. A brief psychiatric assessment was completed by three psychiatrists at the hospital, who concluded that the patient understood the reason why a transfusion may be recommended and the consequences of refusing to have a transfusion.

The child was apprehended by the Director of Child and Family Services as a "child in need of protection" and an order was sought under section 25(8) of the *Act* authorizing blood transfusions. The applications Judge did not review the psychiatric reports or interview the child, believing that, unlike section 25(9) of the *Act*, capacity was irrelevant to a decision under section 25(8) based on the best interests of the child. In his view, and the subsequent opinion of the Manitoba Court of Appeal, the court is authorized to make treatment decisions for children under 16 irrespective of whether they have capacity. Nevertheless, he proceeded, as did the Court of Appeal, on the assumption that A.C. had capacity to make medical decisions. The transfusions were ordered to be administered to the child by competent medical personnel. The child and her parents appealed the decision to the Manitoba Court of Appeal on the basis that the provisions of the statute infringed her rights under the following sections of the *Charter*: section 2(a) (freedom of religion), section 7 (life, liberty and security of the person) and section 15 (equality rights).

C. THE DECISION OF THE MAJORITY

The decision of the majority was written by Madam Justice Abella and joined in by Mr. Justice LeBel, Madam Justice Deschamps and Madam Justice Charron. They upheld the constitutionality of the impugned

provisions of the *Act,* provided that the child's best interests in section 25(8) are properly "interpreted in a way that sufficiently respects his or her maturity in a particular medical decision-making context." [para. 3] Acknowledging that "maturity" is difficult to measure, the majority held that a full assessment of maturity is required in determining the child's best interests. According to the majority opinion, "[i]t is a sliding scale of scrutiny, with the adolescent's views becoming increasingly determinative depending on his or her ability to exercise mature, independent judgment. The more serious the nature of the decision, and the more severe its potential impact on the life or health of the child, the greater the degree of scrutiny that will be required." [para. 22]

The majority opinion concluded that its interpretative approach to "best interests" is consistent with common law principles related to "mature minors," the reality of child development, and the demands of child protection. In a lengthy opinion, Madam Justice Abella examined the legislative scheme, the common law of medical decision making for adults and minors, international jurisprudence and social and scientific literature. A full review of her analysis is beyond the scope of this Bulletin.

1. Common law doctrine of the "mature minor"

An extensive review was undertaken of the common law doctrine of the "mature minor", which was summarized as "a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding." [para. 46] Young people are not automatically denied the right to make treatment decisions but the right varies with the level of maturity, which is more intensely scrutinized in proportion to the severity of the potential consequences of the decision. The "mature minor" doctrine has been used to support minors making their own decisions about such matters as contraception and abortion.

Madam Justice Abella emphasized that the United Kingdom cases, which created the doctrine, do not stand for the proposition that a "mature minor" be treated as an adult for all treatment decisions. Nor does the "mature minor status" oust the court's inherent parens *patriae* jurisdiction when the child's life is in danger. In such cases, the court may "exercise its *parens patriae* jurisdiction to authorize treatment based on an assessment of what could be most conducive to the child's welfare, with the child's view carrying increasing weight in the analysis as his or her maturity increases." [para. 56] As

of the date of the Judgment, no court in the United Kingdom has allowed a child under 16 to refuse beneficial medical treatment.

In Canada, treatment has always been ordered by the courts where the child's refusal would endanger a healthy future. In the Alberta case of *Alberta (Director of Child Welfare) v. (B.),* [2002] 11W.W.R.752 at 761, the Provincial Court Judge, who was upheld on appeal, found that the sixteen year old girl was not mature enough to make the decision to die. Judge Jordan said in part, "[i]ntelligence, thoughtfulness, exemplary behaviour and notable academic achievement are not sufficient when the magnitude of the decision faced by a 16 year-old involves a certain risk of death."

After reviewing case law in the United States and Australia, Madam Justice Abella stated that "[w]hat is clear from the above survey of Canadian and international jurisprudence is that while courts have readily embraced the concept of granting adolescents a degree of autonomy that is reflective of their evolving maturity, they have generally not seen the "mature minor" doctrine as dictating guaranteed outcomes, particularly where the consequences for the young person are catastrophic." [para. 69]

2. Including the "mature minor" doctrine in the "best interests" standard in section 25 (8) of the *Act*

Madam Justice Abella observed that most situations of medical treatment of a minor do not involve life and death issues. The cases that end up in court under section 25 of the *Act* are there because the child protection authorities have determined that medical treatment is necessary to protect the health or life of the child. "In this very limited class of cases, it is the ineffability inherent in the concept of 'maturity' that justifies the state's retaining an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her best interests. The degree of scrutiny will inevitably be most intense in cases where a treatment decision is likely to seriously endanger a child's life or health." [para. 86]

Recognizing the difficulty of defining maturity and reiterating that it is an individualized assessment, Madam Justice Abella identified the following factors that may assist the court in assessing "with respect and rigour" the maturity of adolescents and whether their wishes reflect stable independent choices: [para. 96]

• What is the nature, purpose and utility of the recommended medical treatment? What are the risks and benefits?

• Does the adolescent demonstrate the intellectual capacity and sophistication to understand the information relevant to making the decision and to appreciate the potential consequences?

• Is there reason to believe that the adolescent's views are stable and a true reflection of his or her core values and beliefs?

• What is the potential impact of the adolescent's lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment?

• Are there any existing emotional or psychiatric vulnerabilities?

• Does the adolescent's illness or condition have an impact on his or her decision-making ability?

• Is there any relevant information from adults who know the adolescent, like teachers or doctors?

3. Charter Issues

The majority decision held that once the "best interests" standard in section 25(8) of the *Act* is interpreted to take into account the young person's views in accordance with his or her maturity, the impugned provisions are not arbitrary or discriminatory and do not violate freedom of religion.

There would be no infringement of section 7 of the *Charter* because there is no assumption that everyone one under the age of 16 lacks capacity to make medical treatment decisions. There would be no infringement of section 15 of the *Charter* because the decision is determined not by age but by maturity. There is also no breach of freedom of religion because one of the statutory factors in the "best interests" test is a child's "religious heritage." In addition, increasing the influence of a young person's religious beliefs with the increase in his or her maturity is an appropriate balancing of religious freedom and the protective objective of the *Act.*

4. Conclusion

The majority judgment concluded that "...the best interests test referred to in section 25(8) of the *Act*, properly interpreted, provides that a young person is entitled to a degree of decisional autonomy commensurate with his or her maturity. The result of this interpretation of s. 25(8) is that adolescents

under 16 will have the right to demonstrate mature medical decisional capacity. This protects both the integrity of the statute and the adolescent" which "reflects a proportionate response to the goal of protecting vulnerable young people from harm, while respecting the individuality and autonomy of those who are sufficiently mature to make a particular treatment decision." [paras. 114-115]

D. CONCURRING OPINION

1. "Mature minor" doctrine not applicable

The concurring opinion of Chief Justice McLachlin and Mr. Justice Rothstein was written by the Chief Justice; it concurred with the result but not the reasons of the majority decision. Focusing on the *Act* itself, the Chief Justice held that, with respect to refusal of treatment, the *Act* provides a complete code for children in need of protection, thereby ousting the common law "mature minor" doctrine. This was a key difference with the majority opinion. The effect of this conclusion is that the wishes of the adolescent are simply one factor to be considered by the court and not a potentially determinative factor.

Stressing that the Judge in each case will be required to make an independent analysis of all relevant considerations, Chief Justice McLachlin declined to speculate on whether a Judge would ever under the *Act* decline to order treatment when the probable result would be death. She did, however state that "It is common sense to suggest, however, that the more dangerous the situation from the perspective of the child's security of person, the more compelling must be the case that the child is fully mature not only in matters of intellect and understanding, but in comprehension of the potential life that lies before her and full future impact of her immediate choice." [para. 133]

2. Section 7 of the Charter

The Chief Justice held that while the *Act* deprived A.C. of her "liberty" to refuse treatment and perhaps her "security of the person," it did so in accordance with the principles of fundamental justice. The limits placed on her personal autonomy advanced a genuine state interest and were based on rational not arbitrary grounds.

The limits related to the objective of the statutory scheme to balance society's interest in ensuring that children receive necessary medical care with the protection of minors' autonomy interest to the extent

possible. Vesting treatment authority for children under 16 in the courts is a legitimate response to concerns about the maturity and vulnerability of these children who are more susceptible to the influence of their peers and parents than older children. The Chief Justice pointed out that the judgment required for such a significant personal decision is "not only an intellectual understanding of the proposed treatment and consequences of refusing it but also experience and independence....It requires 'ethical and emotional maturity.'" [para. 143] There is also "the impracticability of reliably testing for them in the crucial and often exigent context of authorizing necessary medical treatment." [para. 143] The statutory scheme reflects the "state's interest in ensuring that the momentous decision to refuse medical treatment by persons under 16 are truly free, informed and voluntary." [para. 144]

The Chief Justice further found that "age 16 was an appropriate marker of maturity for certain purposes" and referred to several other examples where it is used: driving licences, marriage licences, school attendance, full-time employment, young offenders. The distinction that the *Act* makes between children over 16 and those under 16, giving treatment wishes of the former presumptive weight while denying it to the latter simply reflects the reality of how children mature.

3. Section 15 of the *Charter*

The Chief Justice held that A.C.'s claim of discrimination on the grounds of age must fail because the distinction drawn in the *Act* is "ameliorative not invidious", aimed at protecting minors while providing them with a degree of input on the treatment decision.

4. Section 2(a) of the *Charter*

A.C.'s claim that her right to freedom of religion had been infringed also failed, largely because of its close connection to section 7. "Either the *Charter* requires that an ostensibly 'mature' child under 16 have an unfettered right to make all medical treatment decisions, or it does not, regardless of the child's motivation for refusing treatment." [para. 155] The fact that A.C.'s refusal of treatment was based on religious conviction did not "change the essential nature of the claim as one for absolute personal autonomy in decision-making." The limit imposed on freedom of religion can be justified under section 1 of the *Charter* for many of the same reasons that the law is not arbitrary under section 7. The objective of protecting vulnerable young people is pressing and substantial and the statutory

mechanism of giving discretion to order treatment after considering all the circumstances is a proportionate limit on freedom of religion.

E. DISSENTING JUDGMENT

Mr. Justice Binnie delivered a strong dissenting Judgment, describing "forced medical procedures" as "one of the most egregious violations of a person's physical and psychological integrity against the will of an individual whose refusal is based on a strong religious faith." [para. 167]

He found section 25(8) of the *Act* unconstitutional because "…it prevents a person under 16 from establishing that she or he understands the medical condition and the consequences of refusing treatment, and should therefore have the right to refuse treatment whether or not the applications judge considers such refusal to be in the young person's best interests."

Mr. Justice Binnie is critical of the majority's decision because, even if the minor under 16 demonstrates capacity, it is only one "…consideration among others (however much its weight increases in correspondence with the maturity level and the nature of the treatment decision to be made), and is in no way determinative." [para. 194] According to Mr. Justice Binnie, once capacity is determined, the minor should not just have "input" into the judge's decision but make the decision irrespective of her best interests or the judge's views. By contrast, the decision of the majority still vests the decision in the court based on the best interests of the child.

Mr. Justice Binnie's opinion is that the State's interest in protecting vulnerable children disappears when a "mature minor" shows that there is no need for protection because he or she has capacity to make their own decisions about medical treatment.

F. COMMENTARY

It will take some time to absorb all the nuances of this lengthy and complicated decision. Provinces will, however, be reviewing their child welfare legislation to see if it gives adequate weight to the wishes of mature adolescents.

While this case is not primarily about religious freedom, it is noteworthy that once again a significant case about personal autonomy has occurred in the context of religious convictions about medical treatment. For

example, the leading case on personal autonomy for adults concerned a doctor held liable for battery because he gave an unconscious adult Jehovah's Witness a blood transfusion despite the fact that she had signed a card stating clearly that she would not consent to a transfusion (see *Malette v.Shulman* (1990), 72 O.R. (2d) 417 (C.A.)).

The judgment of the majority is a creative response to the *Charter* challenge. By importing the common law doctrine of "mature minor" into the statutory standard of "best interests" of the child, it intends to respect an adolescent's developing maturity while retaining the State's "overarching power" to act in his or her 'best interests." This is similar to the principle that the "mature minor" doctrine does not oust the court's inherent *parens patriae* jurisdiction. The judgment does, however, raise some questions:

1) Given that decisions of this nature arise in the context of child protection hearings when it has already been determined that the life and health of the child is at risk and time is of the essence, the judgment seems somewhat theoretical. With the statute allowing for short notice, dispensing with paperwork and the taking of evidence by telephone, how realistic is it that there be a "full assessment of maturity" as envisioned in the majority judgment? Will that requirement, with its potential for delay, pose further risks to the adolescent's "security of the person" and perhaps even his or her life which is also guaranteed under section 7 of the *Charter*? The Chief Justice referred to the "impracticability" of evaluating a child's maturity in the 'crucial and often exigent context of authorizing medical treatment."

2) Will this decision be limited to the very narrow class of treatment cases in child protection cases where there the life or health of the child is at risk or will it throw into doubt other age based restrictions, (e.g. capacity to marry, licence to drive, right to vote, compulsory attendance at school) substituting a standard of maturity for the traditional marker of age?