Case Comment
*Commentaire d'arrêt*

# Getting Respect: The Mature Minor's Medical Treatment Decisions: *A.C. v. Manitoba (Director of Child and Family Services)*

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## *1. Synopsis*

Medical treatment decisions by a person under age sixteen who, despite being defined as a "child" by statute, nonetheless establishes capacity for mature, independent thought and judgment, require respect. The minor must be afforded the opportunity to demonstrate decision-making capacity, specific to the proposed treatment. Determination of capacity, however difficult, requires careful, sophisticated, judicial assessment and analysis. Respecting the mature minor's decisional capacity is consistent with a "robust" and constitutional interpretation of the best interest test.

On June 26, 2009, in *A.C. v. Manitoba (Director of Child and Family Services)*,[1] the majority of the Supreme Court of Canada reached these conclusions, while preserving the constitutionality of the impugned provisions of Manitoba's *Child and Family Services Act* (*CFSA*).[2]

Binnie J. would have declared the challenged provisions of the *CFSA* unconstitutional under sections 2(a) and 7 of the *Canadian Charter of Rights and Freedoms*.[3] McLachlin C.J.C. (Rothstein J. concurring) would have sustained their *Charter* validity.

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1 2009 SCC 30, [2009] 2 S.C.R. 181, (2009), 65 R.F.L. (6th) 239 [*A.C.* cited to S.C.R.]. The majority judgment was written by Abella J. (LeBel, Deschamps and Charron JJ. concurring).The factual basis for the *A.C.* decision relates to health care decisional competence of a person statutorily defined as a "child." For a subsequent judgment, relating to competence of an adolescent – a person no longer a "child," who has yet to reach majority – see: *P.H. v. Eastern Regional Integrated Health Care Authority and S.J.L.*, 2010 NLTD 34, 17 February 2010, LeBlanc J., which extensively considers the *A.C.* decision.

2 C.C.S.M. c. 80.

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

## *2. Facts*

On April 12, 2006, 56 days before her fifteenth birthday, the Appellant A.C. (her parents being the other Appellants) sought health care at Winnipeg's Health Sciences Centre (HSC), for gastrointestinal bleeding related to her Crohn's disease. She consented to treatment without use of blood transfusions, a course of medical care the treating paediatrician opposed.

From April 12 to 16, 2006, A.C. proposed, integral to her medical treatment, specific alternatives to blood transfusions. Some of them, such as consulting with HSC's Blood Conservation Program, the paediatrician attempted while others he did not. The paediatrician also declined the request of A.C., relating to her specific medical problem, that he consult with two medical specialists in the United States who were vastly experienced in, and widely recognized for, their expertise in bloodless medicine and surgery. He reasoned, evidently on advice of his legal counsel, that he need not collogue with physicians outside Manitoba.[4]

By April 13, 2006, A.C.'s bleeding had stopped. On that date, the paediatrician requisitioned a formal assessment from HSC's department of psychiatry of A.C.'s capacity to decide her medical treatment without blood transfusions. Specifically, he requested: "Please do assess the patient to determine capability to understanding death." The resulting capacity assessment report, signed by three department psychiatrists, concluded A.C. "understands the reason why a transfusion may be recommended, and the consequences of refusing to have a transfusion."[5]

Shortly after midnight on April 16, 2006, A.C.'s internal bleeding resumed. The paediatrician asked A.C. to consent to a transfusion. She refused and again requested alternatives. He then contacted the Director of Child and Family Services. The Director and his counsel treated the capacity assessment report as "irrelevant,"[6] because A.C. was under sixteen years, and thus a "child" under the *CFSA*. A.C. was apprehended without warrant by a social worker on the Director's behalf. The Director next arranged, on short notice to A.C.'s father, a judicial application by telephone, to commence 8:00 a.m. on April 16, for a treatment order under section 25(8) of the *CFSA*.[7] Kaufman J. of Manitoba Court of Queen's Bench presided at the hearing.

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4 Affidavit of A.C. (sworn April 30, 2006), paras. 17, 26, in Appeal Record at 214, 216.

5 *A.C.*, *supra* note 1 at 266-67.

6 *Ibid.* at 200, 268-69, 279.

7 *Supra*, note 3.

Binnie J. noted in his reasons: "At the relevant time, A.C. was being treated (with her consent) using non-blood products and medication to stop her internal bleeding. She had no desire to die, but she wished to live in accordance with her religious belief."[8] Although A.C.'s objection to blood transfusions was based on her personal religious conscience, Binnie J. observed that blood transfusions are "not without risks":

> At a recent International Consensus Conference on Transfusion and Outcomes, which included experts in the field of anesthesiology, intensive care, hematology, oncology, surgery, and patient blood management, and was monitored by the United States Food and Drug Administration and the American and the Austrialian Red Cross, what was described as "an exhaustive review and analysis of the medical literature by a panel of experts" concluded that "The vast majority of studies show an association between red blood cell transfusions and higher rates of complications such as heart attack, stroke, lung injury, infection and kidney failure and death." See www.medicalnewstoday .com/articles/147167.php, "Blood Transfusions and Outcomes", April 23, 2009.[9]

At the brief Queen's Bench hearing on April 16 before Kaufman J., A.C. was not present or represented, and no arrangements were attempted, by the Director or the Court, to telelink her. Counsel represented A.C.'s parents via cell phone while enroute to HSC, then by land line from HSC.[10] The Director's counsel appeared at the court house before Kaufman J., who expressed the view that, since A.C. was under sixteen and her decisional capacity was "irrelevant to his task",[11] he was prepared to assume, without considering or deciding, that A.C. was capable of giving or refusing consent to blood transfusions. Kaufman J. admitted testimony from the apprehending social worker and A.C.'s treating paediatrician, heard a brief statement from A.C.'s father, and received oral submissions from counsel for each of the Director and A.C.'s parents. No meaningful opportunity was afforded for contrary evidence or argument from or on behalf of A.C. to show, for example, that blood transfusions were unnecessary. Kaufman J. granted the application of the Director for an order authorizing blood transfusions, based exclusively on the paediatrician's *untested* evidence that A.C.'s hemoglobin level (the amount of circulating red blood cells) was low and threatened her vital organs. Six hours later, the Director authorized, and the paediatrician imposed, blood transfusions on A.C. over her strenuous objection.[12] No surgery was performed that day.

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8 *A.C.*, *supra* note 1 at 263.
9 *Ibid.* at 282-83 fn. 3.
10 *Ibid.* at 268-69.
11 *Ibid.* at 200.
12 *Ibid.* at 200, 261-62.

Six days later, on April 22, 2006, A.C.'s surgeon successfully performed gastrointestinal surgery on A.C., without the use of blood transfusions, to correct her intermittent intestinal bleeding.[13]

On May 1, the Director terminated his warrantless apprehension of A.C., who was discharged from HSC on May 4, 2006.[14] Ironically, A.C.'s hemoglobin level when she was discharged was the same as, or marginally higher than, it was on either April 16, 2006, when she was forcibly transfused under Kaufman J.'s treatment order, or April 22, 2006, when she received gastrointestinal surgery without blood transfusions.[15]

A.C.'s appeal from Kaufman J.'s April 16 treatment order granted under section 25(8) of the *CFSA* was unanimously dismissed by the Manitoba Court of Appeal on February 5, 2007. On October 25, 2007, A.C. obtained leave to appeal to the Supreme Court of Canada.

### *3. Supreme Court of Canada*

The Supreme Court's decision in *A.C.* is a case of first impression. No final court of appeal of any other country has addressed the constitutional rights of a mature minor to decide his or her own medical care. To put the Supreme Court of Canada's decision in perspective, the specific wording of sections of Manitoba's *CFSA* impugned by A.C. require mention:

> 25(8) Subject to subsection (9), upon completion of a hearing, the court may authorize a medical examination or any medical or dental treatment that the court considers to be in the best interests of the child.
> 25(9) The court shall not make an order under subsection (8) with respect to a child who is 16 years of age or older without the child's consent unless the court is satisfied that the child is unable
>> (a) to understand the information that is relevant to making a decision to consent or not consent to the medical examination or the medical or dental treatment; or
>> (b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical examination or the medical or dental treatment.[16]

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[13] Affidavit of A.C. (April 30, 2006), paras. 7, 30-31, 34 in Appeal Record, Tab 29 at 211, 218-219].

[14] *A.C.*, *supra* note 1 at 270-71.

[15] Affidavit of Dr. Aryeh Shander (sworn May 25, 2006), paras. 19-20, proffered as fresh evidence in the Manitoba Court of Appeal and Supreme Court of Canada in Appellants' Supplementary Record at 7.

[16] *CFSA*, *supra* note 3.

As reported above, Kaufman J. of Manitoba's Queen's Bench, before issuing his treatment order, ruled A.C.'s capacity was "irrelevant to his task"[17] because A.C. was under sixteen and, unlike the situation of mature minors aged sixteen or seventeen, sections 25(8) and 25(9) of the *CFSA* do not limit the court's authority over mature minors below age sixteen.[18] Steel J.A., for the Manitoba Court of Appeal, agreed. In dismissing A.C.'s appeal from Kaufman J.'s treatment order, Steel J.A. ruled sections 25(8) and 25(9) were constitutional because those sections treat "all minors under 16 the same way."[19] She concluded that while the treatment views of a mature minor under age sixteen may be "considered" by a court, they "are not determinative."[20]

On her appeal to the Supreme Court of Canada, A.C. asserted two principal constitutional arguments. First, she argued that if sections 25(8) and 25(9) of the *CFSA* prescribe sixteen as the minimum age for giving medical consent then those subsections unjustifiably infringe sections 2(a), 7 and 15(1) of the *Charter*. Alternatively, she argued that sections 25(8) and 25(9) of the *CFSA* need not be declared unconstitutional if those subsections are judicially construed to recognize the treatment decisions of mature minors under age sixteen.

Both arguments were fueled by A.C.'s cardinal thesis that under the *Charter* treatment decisions of a person under age sixteen who demonstrates mature decisional capacity for the involved medical care require respect by the court and treating doctors.

Abella J., for the four-judge majority, ruled that although A.C.'s constitutional challenge under the *Charter* to sections 25(8) and 25(9) was "technically" dismissed, she nonetheless accepted A.C.'s cardinal thesis in her interpretation of the impugned *CFSA* provisions, and therefore granted her costs "throughout."[21] Binnie J., in dissent, also agreed with A.C.'s cardinal thesis but, unlike Abella J. for the majority, would have declared the impugned sections of the *CFSA* unconstitutional, with costs to A.C.[22] McLachlin C.J.C. (Rothstein J. concurring), on the other hand, would have affirmed the decisions of the lower courts, but with costs to A.C.[23]

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17 *A.C.*, *supra* note 1 at 200.
18 *Supra* note 3.
19 *A.C.*, *supra* note 1 at 203.
20 *Ibid.* at 280.
21 *Ibid.* at 246.
22 *Ibid.* at 291-92.
23 *Ibid.* at 260.

Abella and Binnie JJ. essentially reached the same destination, albeit by different routes, resulting in what could be characterized as a five to two decision. Unlike McLachlin C.J.C., both Abella and Binnie JJ. agreed with A.C. that the treatment decisions of a mature minor under age sixteen "ought to be respected"[24] by courts and by doctors.

Specifically, Binnie J., in dissent, accepted A.C.'s primary constitutional argument and ruled that sections 25(8) and 25(9) of the *CFSA* unjustifiably infringed sections 2(a) and 7 of the *Charter*. Abella J. accepted A.C.'s alternative constitutional argument and substantially redefined the "best interests" test in section 25(8) to make it "constitutionally compliant"[25] when applied to mature minors under age sixteen.

### *4. Constitutional Interpretation of the "Best Interests" Test*

Abella J. began her analysis by noting the common law has "abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding."[26] This is no doubt due to the reality of adolescent development, the advent of the *Charter*, and international instruments such as the United Nations *Convention on the Rights of the Child*[27] and the Council of Europe's *Convention on Human Rights and Biomedicine*.[28]

After a thorough summary of much of the competing case law and academic articles, Abella J. observed that the distinction between a mature minor's right to autonomy and the so-called welfare principle (the notion a mature minor can only consent to *beneficial* medical care or refuse consent to *futile* medical care) "narrows considerably – and often collapses altogether – when one appreciates the extent to which respecting a demonstrably mature adolescent's capacity for autonomous judgment is 'by definition in his or her best interests.'"[29]

Abella J. firmly rejected Manitoba's claim that a minimum set age for medical consent is constitutionally justifiable as a necessary means to obviate any potential difficulty in determining a young person's maturity.

24 *Ibid.* at 232.
25 *Ibid.* at 203.
26 *Ibid.* at 213.
27 Can. T.S. 1992 No. 3.
28 Eur. T.S. No. 164, c. II; see *A.C.*, *supra* note 1 at 234-35.
29 *A.C.*, *ibid*. at 231.

Abella J. was "strongly of the view" that to respect an adolescent's evolving right to autonomous medical decision-making, "a thorough assessment of maturity, however difficult, is required in determining his or her best interests."[30]

> It 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.[31]

Some commentators on the decision have mistakenly concluded that Abella J., like Steel J.A. of the Manitoba Court of Appeal,[32] was of the view the "treatment wishes of children under [age] 16 will never be determinative."[33] Abella J. specifically rejected this notion. She reiterated no less than four times in her majority opinion that a minor's treatment instructions are "increasingly determinative"[34] as the minor's maturity advances. Abella J. censured Kaufman J. for concluding A.C.'s capacity was "irrelevant to his task,"[35] a conclusion which suggested that Kaufman J. erroneously thought the best interests test was a license for the "indiscriminate application of judicial discretion" and which betrayed "a narrow, static and profoundly unrealistic image"[36] of adolescent development.

What does the majority's "robust"[37] constitutional diagnosis of the best interests test, as applied to mature minors under age sixteen, mean in practice for mature minors, doctors, counsel and courts?

In the "vast majority" of situations, where the treatment decision of a minor under the age of sixteen will not "gravely" endanger the minor's "life or health," the treating doctor need not contact a provincial child welfare director or bring the matter to court. The doctor may instead rely on the minor's instructions if the minor "seems to demonstrate sufficient maturity to direct the course of his or her medical care."[38]

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30 *Ibid.* at 197-98.
31 *Ibid.* at 203.
32 *Ibid.* at 280.
33 See e.g. Claire Houston, "Case Comment: *Manitoba (Director of Child and Family Services) v. C. (A.)*" (2009) 65 R.F.L. (6th) 397 at 400.
34 *A.C.*, *supra* note 1 at 203, 233-34, 244-45.
35 *Ibid.* at 200.
36 *Ibid.* at 233.
37 *Ibid.* at 234-45, 256.
38 *Ibid.* at 231.

In the "very limited class of cases" where a minor under age sixteen is refusing treatment that the state believes is necessary to protect the minor's "life or health," then the matter should be brought before a court for decision.[39] (This will not impact provinces such as Ontario, Prince Edward Island, and Yukon which have specific legislation in place governing the process of determining capacity for persons of any age.)[40] If the court determines the minor has the requisite maturity to make the involved treatment decision then, according to the majority, the minor's treatment decision "ought to be respected." The majority opinion of Abella J. stated:

> The more a court is satisfied that a child is capable of making a mature, independent decision on his or her own behalf, the greater the weight that will be given to his or her views when a court is exercising its discretion under s. 25(8). In some cases, courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor. *If, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgment, the court is persuaded that the necessary level of maturity exists, it seems to me necessarily to follow that the adolescent's views ought to be respected.* Such an approach clarifies that in the context of medical treatment, young people under 16 should be permitted to attempt to demonstrate that their views about a particular medical treatment decision reflect a sufficient degree of independence of thought and maturity.[41]

Did Abella J., by employing "ought to be respected," mean that Manitoba courts – and, by extension courts of other provinces with legislation comparable to Manitoba's *CFSA* – *must* respect, or *may exercise discretion whether to* respect, a minor's treatment choices? The French language version of Abella J.'s decision clarifies the matter, stating "qu'il faut respecter ses opinions." In other words, the treatment decision of the mature minor under age sixteen must be respected.[42]

A list of suggested factors a trial court must consider "with respect and rigour"[43] in assessing the maturity (in the sense of capacity to make particular medical treatment decisions) of a person under age sixteen

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39 *Ibid*.

40 *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, s. 4(2), 10(1); *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1996, s. 3(1), 4; *Care Consent Act*, S.Y. 2003, c. 21, Sch. B, ss. 3, 6(2), (3).

41 *A.C.*, *supra* note 1 at 232 [emphasis added]

42 *Ibid*. The French version of the judgment states: "Si, après une analyse approfondie et complexe de la capacité de la jeune personne d'exercer son jugement de façon mature et indépendante, le tribunal est convaincu qu'elle a la maturité nécessaire, il s'ensuit nécessairement, à mon avis, qu'il faut respecter ses opinions."

43 *Ibid.* at 236.

include: (1) whether the minor understands the information relevant to the treatment decision and appreciates its potential consequences; (2) whether the minor's views "are stable and a true reflection of his or her core values and beliefs"; and (3) the potential impact of the minor's "lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment."[44]

Both Abella J. and Binnie J. agreed with the thrust of A.C.'s constitutional arguments under sections 2(a), 7, and 15(1) of the *Charter*. Abella J. stated for the majority:

> In conclusion, I agree with A.C. that it is inherently arbitrary to deprive an adolescent under the age of 16 of the opportunity to demonstrate sufficient maturity when he or she is under the care of the state. It is my view, however, that the "best interests" test referred to in s. 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 of the adolescent. It is also an interpretation that precludes a dissonance between the statutory provisions and the *Charter*, since it enables adolescents to participate meaningfully in medical treatment decisions *in accordance with their maturity*, creating a sliding scale of decision-making autonomy.
> If ss. 25(8) and 25(9) did in fact grant courts an unfettered discretion to make decisions on behalf of all children under 16, despite their actual capacities, while at the same time presuming that children 16 and over were competent to veto treatment they did not want, I would likely agree that the legislative scheme was arbitrary and discriminatory. A rigid statutory distinction that completely ignored the actual decision-making capabilities of children under a certain age would fail to reflect the realities of childhood and child development.[45]

So, what is the difference between the "dissenting" reasons of Binnie J. and the majority reasons of Abella J.?

Binnie J. agreed with the argument of the Director and the reasons of Steel J.A. that the language of section 25(8) of the *CFSA* prescribes an "irrebuttable presumption of incapacity"[46] under age sixteen. Steel J.A. described this as a "modified mature minor rule"[47] – treatment decisions of capable persons age sixteen and seventeen are respected while treatment decisions of persons below the arbitrary age of sixteen are not.

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44 *Ibid*.
45 *Ibid.* at 244-45 [emphasis added].
46 *Ibid.* at 265, 279-80 .
47 *Ibid.* at 280.

Binnie J. ruled that an irrebuttable presumption of incapacity "serves no valid state purpose,"[48] is "arbitrary,"[49] and therefore is contrary to substantive justice under section 7 of the *Charter*. Put simply, this is because the purpose of the *CFSA* is to protect children who cannot look after themselves which means, by definition, incapable children. Mature minors, however, are persons who have been found to be capable of protecting themselves and not in need of state protection. For much the same reason, Binnie J. found the impugned provisions of the *CFSA* when used to authorize an unwanted blood transfusion contrary to a mature minor's religious conscience, unjustifiably violated section 2(a) of the *Charter*.

For Abella J., the "best interests" test contained in section 25(8) of the *CFSA* is an elastic concept that can be reshaped and redefined by a constitutional diagnosis. Competent adults are "assumed to be 'the best arbiter[s] of [their] own moral destiny' and so are entitled to independently assess and determine their own best interests, regardless of whether others would agree when evaluating the choice from an objective standpoint."[50] In a similar way, according to Abella J., the integrity of the statute and of the mature minor can be protected by a "robust"[51] interpretation of the "best interests" test in section 25(8) that recognizes a mature minor's constitutional right to autonomous treatment decision-making. Unlike the making of treatment decisions by adults, treatment choices by minors under age sixteen may require a court, in a "very limited class of cases"[52] to make the final determination whether the treatment decision is in the mature minor's best interests. As Abella J. makes clear, the court's discretion to make that determination is not unfettered. Instead, the court's determination of the best interests of a mature minor under age sixteen will be confined to a "careful and comprehensive evaluation"[53] of the minor's maturity. Of course, the minor cannot be held to a higher standard of decisional capacity than is reasonably expected of adults. If the minor demonstrates he or she has "the necessary level of maturity," in relation to involved medical care, then Abella J.'s constitutionally redefined "best interests" test means the minor's treatment decision "ought to [in the sense of "must"] be respected."[54]

48 *Ibid.* at 284-85.
49 *Ibid.* at 285.
50 *Ibid.* at 230.
51 *Ibid.* at 234-35, 256.
52 *Ibid.* at 231.
53 *Ibid.* at 235-36.
54 *Ibid.* at 232.

## *5. Conclusion*

Not all minors under age sixteen will have the maturity to make serious medical treatment decisions. Perhaps many will not. What *A.C.* establishes is that of a young person, defined as a "child" by statute (under age sixteen in Manitoba), who is found either by her doctor or by a court, to be mature in respect of the involved medical treatment, is entitled to make her own treatment decisions, no matter how serious their nature and potential impact. Five of the seven judges of the Supreme Court of Canada who decided this appeal agreed that the *Charter* entitles medical treatment decisions of mature youths, like A.C., to respect.