SUPREME COURT OF CANADA

CITATION: A.C. *v.* Manitoba (Director of Child and Family Services), 2009 SCC 30

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BETWEEN:

A.C., A.C. and A.C.
Appellants
and
Director of Child and Family Services
Respondent
- and -
Attorney General of Manitoba, Attorney General of British Columbia, Attorney General of Alberta and Justice for Children and Youth
Interveners

CORAM: McLachlin C.J. and Binnie, LeBel, Deschamps, Abella, Charron and Rothstein JJ.

REASONS FOR JUDGMENT: Abella J. (LeBel, Deschamps and Charron JJ. concurring)
(paras. 1 to 122)

CONCURRING REASONS: McLachlin C.J. (Rothstein J. concurring)
(paras. 123 to 161)

DISSENTING REASONS: Binnie J.
(paras. 162 to 239)

A.C. et al. *Appellants*

v.

Director of Child and Family Services *Respondent*

and

Attorney General of Manitoba, Attorney General of British Columbia, Attorney General of Alberta and Justice for Children and Youth *Interveners*

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Neutral citation: 2009 SCC 30.

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2008: May 20; 2009: June 26.

Present: McLachlin C.J. and Binnie, LeBel, Deschamps, Abella, Charron and Rothstein JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR MANITOBA

Constitutional law — Charter of Rights — Liberty and security of person — Fundamental justice — Medical treatment — Child under 16 years of age refusing blood transfusions because her religion requires that she abstain from receiving blood — Transfusion necessary to avoid severe consequences to child's health — For child under 16, provincial child and family services legislation authorizing court to order treatment that it considers in best interests of child — For child 16 and over, no medical treatment can be ordered by court without child's consent unless court satisfied that child lacks ability to understand relevant information or consequences of treatment decision — Whether legislation arbitrary because it deprives children under 16 of opportunity to demonstrate capacity — Whether legislation infringes child's liberty and security interests in manner contrary to principles of fundamental justice — Canadian Charter of Rights and Freedoms, s. 7 — Child and Family Services Act, C.C.S.M. c. C80, s. 25(8), (9).

Constitutional law — Charter of Rights — Equality rights — Discrimination on basis of age — Child under 16 years of age refusing blood transfusions because her religion requires that she abstain from receiving blood — Transfusion necessary to avoid severe consequences to child's health — For child under 16, provincial child and family services legislation authorizing court to order treatment that it considers in best interests of child — For child 16 and over, no medical treatment can be ordered by court without child's consent unless court satisfied that child lacks ability to understand relevant information or consequences of treatment decision — Whether legislation infringes child's equality rights — Canadian Charter of Rights and Freedoms, s. 15 — Child and Family Services Act, C.C.S.M. c. C80, s. 25(8), (9).

Constitutional law — Charter of Rights — Freedom of religion — Child under 16 years of age refusing blood transfusions because her religion requires that she abstain from receiving blood — Transfusion necessary to avoid severe consequences to child's health — For child under 16, provincial child and family services legislation authorizing court to order treatment that it considers in best interests of child — For child 16 and over, no medical treatment can be ordered by court without child's consent unless court satisfied that child lacks ability to understand relevant information or consequences of treatment decision — Whether legislation infringes child's freedom of religion — If so, whether infringement justifiable — Canadian Charter of Rights and Freedoms, ss. 1, 2(a) — Child and Family Services Act, C.C.S.M. c. C80, s. 25(8), (9).

Status of persons — Child protection — Care while under apprehension — Court order authorizing treatment — Maturity — For child under 16, provincial child and family services legislation authorizing court to order treatment that it considers in "best interests" of child — For child 16 and over, no medical treatment can be ordered by court without child's consent unless court satisfied that child lacks ability to understand relevant information or consequences of treatment decision — Whether young person under 16 entitled to demonstrate sufficiency of maturity in medical treatment decisions — Interpretation of "best interests" standard — Child and Family Services Act, C.C.S.M. c. C80, s. 25(8), (9).

C was admitted to hospital when she was 14 years, 10 months old, suffering from lower gastrointestinal bleeding caused by Crohn's disease. She is a devout Jehovah's Witness and, some months before, had signed an advance medical directive containing her written instructions not to be given blood under any circumstances. Her doctor believed that internal bleeding created an

imminent, serious risk to her health and perhaps her life. She refused to consent to the receipt of blood. A brief psychiatric assessment took place at the hospital on the night after her admission. The Director of Child and Family Services apprehended her as a child in need of protection, and sought a treatment order from the court under s. 25(8) of the Manitoba *Child and Family Services Act*, by which the court may authorize treatment that it considers to be in the child's best interests. Section 25(9) of the Act presumes that the best interests of a child 16 or over will be most effectively promoted by allowing the child's views to be determinative, unless it can be shown that the child does not understand the decision or appreciate its consequences. Where the child is under 16, however, no such presumption exists. The applications judge ordered that C receive blood transfusions, concluding that when a child is under 16, there are no legislated restrictions of authority on the court's ability to order medical treatment in the child's "best interests". C and her parents appealed the order arguing that the legislative scheme was unconstitutional because it unjustifiably infringed C's rights under ss. 2(*a*), 7 and 15 of the *Canadian Charter of Rights and Freedoms*. The Court of Appeal upheld the constitutional validity of the impugned provisions and the treatment order.

Held (Binnie J. dissenting): The appeal should be dismissed. Sections 25(8) and 25(9) of the *Child and Family Services Act* are constitutional.

Per LeBel, Deschamps, Charron and **Abella** JJ.: When the young person's best interests are interpreted in a way that sufficiently respects his or her capacity for mature, independent judgment in a particular medical decision-making context, the constitutionality of the legislation is preserved. Properly construed to take an adolescent's maturity into account, the statutory scheme

strikes a constitutional balance between what the law has consistently seen as an individual's fundamental right to autonomous decision making in connection with his or her body, and the law's equally persistent attempts to protect vulnerable children from harm. The "best interests" standard in s. 25(8) operates as a sliding scale of scrutiny, with the child's views becoming increasingly determinative depending on his or her maturity. The more serious the nature of the decision and the more severe its potential impact on life or health, the greater the degree of scrutiny required. The result of this interpretation of s. 25(8) is that young people under 16 will have the right to demonstrate mature medical decisional capacity. This protects both the integrity of the statute and of the adolescent. [3][22] [30][114]

Mature adolescents have strong claims to autonomy, but these claims exist in tension with a protective duty on the part of the state that is justified by the difficulty of defining and identifying "maturity". Any solution to this tension must be responsive to its complexity. Where a child under 16 comes before the court under s. 25 of the *Child and Family Services Act*, 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. But "best interests" must in turn be interpreted so as to reflect and respect the adolescent's developing autonomy interest. The more a court is satisfied that a child is capable of making a truly mature and independent decision on his or her own behalf, the greater the weight that must be given to his or her views when a court is exercising its discretion under s. 25(8). If, after a careful analysis of the young person's ability to exercise mature and independent judgment, the court is persuaded that the necessary level of maturity exists, the young person's views ought to be respected. [95]

In assessing an adolescent's maturity in a s. 25(8) "best interests" analysis, a judge should take into account the nature, purpose and utility of the recommended medical treatment and its risks and benefits; the adolescent's intellectual capacity and the degree of sophistication to understand the information relevant to making the decision and to appreciate the potential consequences; the stability of the adolescent's views and whether they are a true reflection of his or her core values and beliefs; the potential impact of the adolescent's lifestyle, family relationships and broader social affiliations on his or her ability to exercise independent judgment; the existence of any emotional or psychiatric vulnerabilities and the impact of the adolescent's illness on his or her decision-making ability. Any relevant information from adults who know the adolescent may also factor into the assessment. [95]

When the "best interests" standard is properly interpreted, the legislative scheme created by ss. 25(8) and 25(9) of the *Child and Family Services Act* does not infringe ss. 7, 15 or 2(*a*) of the *Charter* because it is neither arbitrary, discriminatory, nor violative of religious freedom. Under s. 7 of the *Charter*, while it may be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions, it is not arbitrary to give them the opportunity to prove that they have sufficient maturity to do so. [96][106]

With respect to s. 15, in permitting adolescents under 16 to lead evidence of sufficient maturity to determine their medical choices, their ability to make treatment decisions is ultimately calibrated in accordance with maturity, not age, and no disadvantaging prejudice or stereotype based on age can be said to be engaged. [110]

Similarly, since a young person is entitled to lead evidence of sufficient maturity, the impugned provisions do not violate a child's religious convictions under s. 2(*a*). Consideration of a child's "religious heritage" is one of the statutory factors which a judge must consider in determining the "best interests" of a child under s. 25(8), and expanding the deference to a young person's religious wishes as his or her maturity increases is a proportionate response both to the young person's religious rights and the protective goals of s. 25(8). [28] [111] [112]

Interpreting the best interests standard so that a young person is afforded a degree of bodily autonomy and integrity commensurate with his or her ability to exercise mature, independent judgment navigates the tension between an adolescent's increasing entitlement to autonomy as he or she matures and society's interest in ensuring that young people who are vulnerable are protected from harm. This brings the "best interests" standard in s. 25(8) in line with the evolution of the common law and with international principles, and strikes an appropriate balance between achieving the protective legislative goal while at the same time respecting the right of mature adolescents to participate meaningfully in decisions relating to their medical treatment. [107]

Per McLachlin C.J. and Rothstein J.: The *Child and Family Services Act* is a complete code for medical decision-making for or by apprehended minors. It requires the judge to be satisfied that a treatment order is in the child's best interests by undertaking an independant analysis of all relevant circumstances and the factors in s. 2(1) of the Act, including the child's needs, mental and emotional maturity and preferences. This multi-factored "best interests of the child" approach required by s. 25(8) does not operate unconstitutionally in the case of a child under 16 who possesses capacity to make a treatment decision and understands the nature and consequences of the

treatment. [123] [126] [132-135]

Section 25(8) of the *Child and Family Services Act* does not violate s. 7 of the Charter. This provision, although it deprives a child under 16 of the "liberty" to decide her medical treatment and may impinge on her "security of person", does not function in a manner that is contrary to the principles of fundamental justice. The s. 7 liberty or autonomy right is not absolute, even for adults, nor does it trump all other values. Limits on personal autonomy that advance a genuine state interest do not violate s. 7 if they are shown to be based on rational, rather than arbitrary grounds. Here, when the relationship between s. 25(8) and the state interest at stake are considered, the statutory provision is not arbitrary in the substantive sense. The statutory scheme successfully balances society's interest in ensuring that children receive necessary medical care on the one hand, with the protection of their autonomy interest, to the extent this can be done, on the other. The legislative decision to vest treatment authority regarding under-16 minors in the courts is a legitimate response to heightened concerns about younger adolescents' maturity and vulnerability to subtle and overt coercion and influence. This concern with free and informed decision-making animates the legislative scheme and expresses the state's interest in ensuring that the momentous decision to refuse medical treatment by persons under 16 are truly free, informed and voluntary. Age, in this context, is a reasonable proxy for independence. The Act requires the judge to take account of the treatment preference of a minor under 16 as a factor in assessing the child's "best interests", while refusing to give it the presumptive weight it would carry with a child over 16. This distinction reflects the societal reality of how children mature, and the dependence of children under 16 on their parents, as well as the difficulty of carrying out a robust and comprehensive analysis of maturity and voluntariness in the exigent circumstances of crucial treatment decisions in cases such as C's.

Further, the s. 7 requirement that the limitation be carried out in a procedurally fair manner is satisfied by the notice and participation requirements in the *Child and Family Services Act*. [136-138] [141] [143-148] [161]

Section 25(8) does not violate s. 15 of the *Charter*. The distinction drawn by the Act between children under 16 and those 16 and over is ameliorative and not invidious. First, it aims at protecting the interests of minors as a vulnerable group. Second, it protects the targeted group — children under 16 — in a way that gives the individual child a degree of input into the ultimate decision on treatment. This is sufficient to demonstrate that the distinction drawn by the Act, while based on an enumerated ground, is not discriminatory within the meaning of s. 15. [150] [152]

Finally, while the legislative authorization of treatment over C's sincere religious objections constitutes an infringement of her right to religious freedom guaranteed by s. 2(*a*) of the *Charter*, the infringement is justifiable under s. 1. The fact that C's aversion to receiving a blood transfusion springs from religious conviction does nothing to alter the essential nature of the claim as one for absolute personal autonomy in medical decision-making. If s. 25(8) is viewed through the lens of s. 2(*a*), the limit on religious practice imposed by the legislation emerges as justified under s. 1, because the objective of ensuring the health and safety and of preserving the lives of vulnerable young people children is pressing and substantial, and the means chosen — giving discretion to the court to order treatment after a consideration of all relevant circumstances — is a proportionate limit on the right. [153-156]

The applications judge assumed that C had "capacity" to make the treatment decision

but, after considering the relevant factors set out in s. 2(1) of the *Child and Family Services Act* including her maturity and including her wish not to have the treatment, concluded that treatment was in the child's best interests. This decision conformed to the provisions of the Act. While, if time and circumstances permit, it is optimal for a judge to fully consider and give reasoned judgment on all the factors he or she takes into account, proceeding on the assumption of "capacity" — an assumption that favoured C's autonomy interest — was reasonable in these circumstances where a child's life hung in the balance and the need for a decision was urgent. [157] [159]

Per Binnie J. (dissenting): Forced medical procedures must be one of the most egregious violations of a person's physical and psychological integrity. The state's interest in ensuring judicial control over the medical treatment of "immature" minors ceases to exist where a "mature" minor under 16 *demonstrates* the lack of need for any such overriding state control. In such cases, the legitimate object and basis of state intervention in the life of the young person has, by reason of the judge's finding of maturity, disappeared. Whether judges, doctors and hospital authorities agree or disagree with C's objection, the decision belongs to her, as the *Charter* is not just about the freedom to make the wise and correct choice; it also gives her the individual autonomy and the religious freedom to refuse forced medical treatment, even where her life or death hangs in the balance, regardless of what the judge thinks is in her best interest. The state would be justified in taking the decision away from C if there was any doubt about her capacity, as in a situation of urgency, or whether she was acting under the influence of her parents (who are Jehovah's Witnesses). However, these matters were looked into by three psychiatrists at the Winnipeg hospital where the blood transfusion was to be administered, and the psychiatrists concluded, and the applications judge accepted, that C — though 14 months short of reaching 16 years of age — was

nevertheless at the materail time an individual "with the capacity to give or refuse consent to her own medical care". [163-167] [177] [237]

Children may generally be assumed to lack the requisite degree of capacity and maturity to make potentially life-defining decisions. This lack of capacity and maturity provides the state with a legitimate interest in taking the decision-making power away from the young person and vesting it in a judge under the *Child and Family Services Act.* At common law, proof of capacity entitles the "mature minor" to exercise personal autonomy in making medical treatment decisions free of parental or judicial control. While it may be very difficult to persuade a judge that a young person who refuses potentially life-saving medical treatment is a person of full capacity, nonetheless, the Charter requires such an opportunity to be given in the case of an adolescent of C's age and maturity. The Act mandates an individualized assessment on a patient-by-patient basis, and courts routinely handle capacity as a live issue under the *Child and Family Services Act* in the case of minors between the ages of 16 and 18. Section 25(8) is 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. [175-178]

While it is understandable that judges would instinctively give priority to the sanctity of life, the rejection of the potentially lifesaving effects of blood transfusions by Jehovah's Witnesses is fundamental to their religious convictions. The rights under ss. 2(*a*) and 7 of the *Charter* are given to everyone, including individuals under 16 years old. If a mature minor does in fact understand the nature and seriousness of her medical condition and is mature enough to

appreciate the consequences of refusing consent to treatment, then the state's only justification for taking away the autonomy of that young person in such important matters disappears. The young person with capacity is entitled to *make* the treatment decision, not just to have "input" into a judge's consideration of what the judge believes to be the young person's best interests. [191-192] [202] [207] [214]

The irrebuttable presumption of incapacity to consent to or refuse medical treatment therefore violates C's freedom of religion and her right not to be deprived of her liberty or security of the person except in accordance with the principles of fundamental justice. It was rightly conceded that s. 25 violated s. 2(*a*), subject to the s. 1 defence advanced by the government. [211] [215]

With respect to s. 7, C's liberty interest is directly engaged because it is obvious that anyone who refuses a potentially life-saving blood transfusion on religious grounds does so out of a deeply personal and fundamental belief about how they wish to live, or cease to live, in obedience to what they interpret to be God's commandment. Her security interest is also engaged because an unwanted blood transfusion violates the fundamental value of protecting bodily integrity from state interference. The principles of fundamental justice that are breached in this case are both procedural and substantive. In terms of substantive justice, the irrebuttable presumption takes away the personal autonomy of C and other "mature minors" for no valid state purpose. The purpose of the *Child and Family Services Act* is to defend the "best interest" of children who are "in need of protection" — this means, in this context, children who do not have the capacity to make their own decisions about medical treatment. When applied to young persons who possess the requisite capacity, the

irrebuttable presumption has "no real relation" to the legislative goal of protecting children who do *not* possess such capacity. The deprivation in the case of mature minors is thus arbitrary and violates s. 7. In terms of procedural justice, the procedures in the Act are also deficient because they do not afford a young person the opportunity to rebut the very presumption upon which the court's authority to act in the best interests of the young person rests, namely lack of capacity. Where (as in this case) a young person's capacity can fairly be determined in a timely way, s. 25(8)'s failure to leave room for the young person to rebut the presumption of incapacity violates fundamental procedural fairness. [219-225]

The limit imposed by the irrebuttable presumption on C's ss. 2(*a*) and 7 rights is not justifiable under s. 1 of the *Charter*. The care and protection of children is a pressing and substantial legislative objective that is of sufficient importance to justify limiting a *Charter* right. However, the impugned procedure under s. 25 of the Act is not rationally connected to that objective. Since the Act itself acknowledges in s. 25(9) that mature minors 16 and over are presumed to be of sufficient capacity to make their own treatment decisions, it is "arbitrarily unfair or based on irrational considerations" to deny mature minors under 16 the opportunity of demonstrating what in the case of the older mature minors is presumed in their favour. Furthermore, the irrebuttable presumption of incapacity does not impair "as little as possible" the right or freedom in question as shown by the fact that the Manitoba legislature has enacted a rebuttable presumption in other health care statutes. Such a rebuttable presumption provides an available legislative solution that both protects the state interest in looking out for those who lack the capacity to look out for themselves and the need to impair minimally the rights of mature minors under 16 years of age who do not lack that capacity. Finally, the irrebuttable presumption has a disproportionately severe effect on the

rights of mature minors under 16 because they do not suffer from the lack of capacity or maturity that justifies the state intervention in relation to immature minors. Moreover, the government has not shown that the irrebuttable presumption in the Act produces "proportionality between the deleterious and salutary effects" because while the mature minor's Charter rights are harmed, the state's interest in protecting the health of *immature* minors is not advanced. [233-237]

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By Abella J.

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By Binnie J. (dissenting)

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Health Care Directives Act, C.C.S.M. c. H27, s. 4(2).

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Mental Health Act, C.C.S.M. c. M110, s. 2.

United States Constitution, First Amendment, Fourteenth Amendment.

Treaties and Other International Instruments

Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Eur. T.S. No. 164, c. II, art. 6.

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APPEAL from a judgment of the Manitoba Court of Appeal of Manitoba (Huband, Steel and Hamilton JJ.A.), 2007 MBCA 9, 212 Man. R. (2d) 163, 389 W.A.C. 163, 276 D.L.R. (4th) 41, [2007] 4 W.W.R. 62, 151 C.R.R. (2d) 191, [2007] M.J. No. 26 (QL), 2007 CarswellMan 28, affirming an order of Kaufman J. Appeal dismissed, Binnie J. dissenting.

David C. Day, Q.C., and *Allan Ludkiewicz*, for the appellant A.C. (child).

Shane H. Brady, for the appellants A.C. and A.C.

Norm Cuddy, *Alfred Thiessen* and *Kristian J. Janovcik*, for the respondent.

Deborah L. Carlson and *Nathaniel Carnegie*, for the intervener the Attorney General of Manitoba.

Neena Sharma and *Karrie Wolfe*, for the intervener the Attorney General of British Columbia.

Margaret Unsworth, Q.C., and *Lillian Riczu*, for the intervener the Attorney General of

Alberta.

Cheryl Milne and *Mary Birdsell*, for the intervener Justice for Children and Youth.

The judgment of LeBel, Deschamps, Abella and Charron JJ. was delivered by

ABELLA J. —

[1] One of the most sensitive decisions a judge can make in family law is in connection with the authorization of medical treatment for children. It engages the most intensely complicated constellation of considerations and its consequences are inevitably profound.

[2] When a child under 16 is apprehended in Manitoba pursuant to the *Child and Family Services Act*, C.C.S.M. c. C80, and where the child or his or her parents refuse essential medical treatment, the court may authorize treatment that it considers to be "in the best interests" of the child. If the apprehended child is 16 or over, no medical treatment can be ordered by the court without the child's consent unless the court is satisfied that the child lacks the ability to understand either the relevant information or the consequences of the treatment decision.

[3] The main issue in this appeal is whether those provisions of the *Child and Family Services Act* are constitutional. In my view, if the young person's best interests are interpreted in a way that sufficiently respects his or her maturity in a particular medical decision-making context,

the constitutionality of the legislation is preserved.

[4] I acknowledge that because we are dealing with the inherent imprecision of childhood and adolescent development, maturity is necessarily an imprecise standard. There is no judicial divining rod that leads to a "eureka" moment for its discovery; it depends on the court's assessment of the adolescent, his or her circumstances and ability to exercise independent judgment, and the nature and consequences of the decision at issue. But I am nonetheless strongly of the view that in order 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.

BACKGROUND

[5] A.C. was 14 years and 10 months old when she was admitted to the hospital on April 12, 2006. She suffered an episode of lower gastrointestinal bleeding as a result of Crohn's disease. A.C. is a Jehovah's Witness who believes that her religion requires that she abstain from receiving blood.

[6] A few months before her admission to the hospital, A.C. had completed an "advance medical directive" with written instructions that she not receive blood transfusions under any circumstances. On April 13, the day after A.C.'s admission, Dr. Stanley Lipnowski, the doctor treating her at the hospital, requested that the hospital's
Department of Psychiatry undertake an assessment of A.C. "to determine capability to understanding death". The report, completed by three psychiatrists that night between 10:00 p.m. and 11:45 p.m.

after an interview with the girl and her parents, did not use the word "capacity". Instead, the report indicated that A.C. was "alert and cooperative . . . very well spoken. Mood 'fairly good'. . . . [B]right, [slightly] teary at times, full range and appropriate". Her parents fully supported A.C.'s decision and told the psychiatrists that A.C. "treasures her relationship with God and does not want to jeopardize it, that she understands her disease and what is happening". The report concluded that A.C. had "no psychiatric illness at present" and that:

> The patient understands the reason why a transfusion may be recommended, and the consequences of refusing to have a transfusion.

[7] At the time of her assessment, A.C.'s condition was stable and continued to stabilize for a few days, but on the morning of April 16, she experienced more internal bleeding. Her doctors wanted to give her a blood transfusion. She refused.

[8] As a result, the Director of Child and Family Services apprehended her as a child in need of protection under the *Child and Family Services Act*.

[9] A court order was requested under ss. 25(8) and 25(9) of that Act, authorizing qualified medical personnel to administer blood transfusions to A.C. as deemed necessary by the attending physician. Those provisions state:

> **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.

[10] The emergency application was heard by Kaufman J. Counsel for the Director of Child and Family Services was in the courtroom. Others, including Dr. Lipnowski, counsel for the Winnipeg Regional Health Authority, counsel for A.C.'s parents, a social worker, and A.C.'s father, were together in a hospital boardroom and participated in the hearing by conference call. A.C. did not participate.

[11] Dr. Lipnowski's evidence was that the transfusions were necessary because the risk to A.C. if she did not receive blood was "significant":

> [T]he longer she goes without, the more the risk is of her having serious oxygen deprivation to the point where [if] for argument sake she's not getting enough oxygen to her kidneys, they will shut down and cause essential poisoning of her system. If she does not get enough oxygen to her brain she can conceivably have seizures and other manifestations of the brain that will contribute to a faster demise or death.

[12] Kaufman J. granted the treatment order. At the urging of her counsel, he agreed to proceed on the assumption that A.C. had "capacity" to make medical decisions because, in his view, her capacity was irrelevant to his task. Even though she did not wish to receive blood, he concluded that when a child is under 16 years old, "there are no legislated restrictions of the authority" on the court's ability to order medical treatment in the child's "best interests" under s. 25(8) of the *Child and Family Services Act*. He was satisfied, based on the testimony of Dr. Lipnowski, that A.C. was "in immediate danger as the minutes go by, if not [of] death, then certainly serious damage".

[13] About six hours later, A.C. was given three units of blood. The treatments were

successful and A.C. recovered. On May 1, the Director withdrew its application.

[14] A.C. and her parents appealed the order of Kaufman J. on alternative grounds. First, they argued that s. 25(8) of the Act, and the "best interests" test contained in it, applies only to minors under 16 without capacity, and so should not have been applied to A.C. Alternatively, they argued that ss. 25(8) and 25(9) of the *Child and Family Services Act* were unconstitutional because they unjustifiably infringed A.C.'s rights under ss. 2(*a*), 7 and 15 of the *Canadian Charter of Rights and Freedoms*, which state:

> **2.** Everyone has the following fundamental freedoms:
>
> (*a*) freedom of conscience and religion;
>
> **7.** Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> **15.** (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[15] On appeal, Steel J.A., for a unanimous court, confirmed at the outset that the issue was not A.C.'s capacity, stating:

> . . . The court confirmed with counsel that this court would deal with the interpretation of the legislation on the same basis as the motions judge; that is, that s. 25(8) was based on the best interests test even if the minor had capacity. Therefore, this would not be a decision as to whether the minor in question, A.C., had capacity in this particular case. [para. 21]

She rejected A.C.'s argument that s. 25(8) applies only to children under 16 without capacity: 2007 MBCA 9, 212 Man. R. (2d) 163. The Court of Appeal concluded that the legislation ousts the

common law principles relating to "mature minors", and instead empowers the court to make treatment decisions for those under 16, with or without capacity, based on a "best interests" test. A child's wishes and capacity are relevant to the analysis, but not determinative. She concluded that the *Child and Family Services Act* formed "a complete and exclusive code for dealing with refusal of medical treatment in circumstances where an application is made under s. 25 of the *CFSA*" (para. 61).

[16] In evaluating the strength of A.C.'s claim under s. 7 of the *Charter*, Steel J.A. identified the competing interests at stake as being the interest an adolescent has in his or her personal autonomy and, on the other hand, the state's interest in the protection of children and the sanctity of life. In her view, s. 25 of the *Child and Family Services Act* successfully balanced these interests. It was not "arbitrary" to adopt the age of 16 as the "presumptive line", because it cannot be said that the law "bears no relation to, or is inconsistent with, the objective that lies behind [it]" (para. 79, citing *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at pp. 594-95).

[17] Four foundations grounded Steel J.A.'s conclusion that the threshold age of 16 was not arbitrary:

> First, a fixed age has been chosen as the dividing line for other purposes regarding children and fundamental life choices. We do not allow children, whether they are mature minors or not, to determine whether to attend school, to determine where to live when their parents divorce (although their wishes may be considered) or to decide to marry. Second, the requirement for an individual assessment in the case of a child under 16 may not adequately protect children in an emergency situation where a court must consider a wide variety of variables, including the different physical, emotional and intellectual maturity of each child in a time-limited situation. Third, the level for intervention is life threatening. In this type of situation, the state has chosen a measured

> policy which allows for less discretion on the part of younger teenagers and more discretion on the part of older teenagers.
>
> Finally, the determination is made within the context of a best interests test, taking into account the child's wishes and capacity. The best interests test has been used historically and is internationally recognized. [paras. 79-80]

[18] The Court of Appeal also concluded that any breach of A.C.'s s. 2(*a*) right to freedom of religion was justified under s. 1 of the *Charter*. The objective of the legislation, "protecting the life and health of children", was clearly pressing and substantial. The rational connection and minimal impairment branches of the *Oakes* test ([1986] 1 S.C.R. 103) were also met for substantially the same reasons that led the court to conclude that the scheme did not violate s. 7.

[19] Finally, Steel J.A. found that there was no breach of s. 15, A.C.'s equality rights, because there was no "arbitrary marginalization" of children since the legislation "attempts to respond to the dependency and reduced maturity of children as a group" (para. 105).

[20] Steel J.A. offered some concluding guidance for the judicial conduct of these difficult proceedings. The procedure "must be adapted to the nature of the medical emergency that exists" and "should be conducted with appropriate procedural safeguards" (para. 110), but the opinions of medical personnel are not determinative. The court should, as directed by the *Child and Family Services Act*, and, "where possible", give the child "a meaningful, age-appropriate opportunity to participate in the proceedings" (para. 113) and take those views into account.

[21] I agree with Steel J.A. that the provisions are constitutional and I agree with much of her thoughtful analysis. With respect, however, I disagree with her interpretive conclusion that s. 25(8) of the Act "treats all minors under 16 the same way" (para. 49). In my view, to be

constitutionally compliant, the interpretation of "best interests" in s. 25(8) of the Act requires that sufficient account be taken of a particular adolescent's maturity in any given medical treatment context.

[22] 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.

[23] This interpretation of the "best interests" standard in s. 25(8) of the Act is not only more consistent with the actual developmental reality of young people; it is also conceptually consistent with the evolutionary development of the common law "mature minor" doctrine in both the Canadian and international jurisprudence. Under this doctrine, courts have readily accepted that an adolescent's treatment wishes should be granted a degree of deference that is reflective of his or her evolving maturity. Notably, however, they have rarely viewed this mandate as being inconsistent with their overarching responsibility to protect children from harm.

ANALYSIS

[24] Under the *Child and Family Services Act*, where either the child or the child's parents refuse to consent to recommended medical treatment, the court has the power under s. 25(8) to consider whether authorizing treatment against the wishes of the parents and/or child is in the child's best interests. Section 25(9) presumes that the best interests of a child 16 or over will be most effectively promoted by allowing the child's views to be determinative, unless it can be shown that

the child lacks the maturity to understand the decision or appreciate its consequences. Where the child is under 16, no such presumption exists.

[25] The heart of A.C.'s constitutional argument is that there is, in essence, an irrebuttable presumption of incapacity in the Act for those under 16, and that this renders ss. 25(8) and 25(9) of the *Child and Family Services Act* contrary to ss. 2(*a*), 7 and 15 of the *Charter*. She does not challenge the constitutionality of a cut-off age of 16; she challenges the constitutionality of depriving those under 16 of an opportunity to prove that they too have sufficient maturity to direct the course of their medical treatment. Her submission is that at common law, mature minors, similar to adults, have the capacity to decide their own medical care. In failing to recognize this "deeply rooted" right, the statutory scheme, she argues, infringes the *Charter*.

[26] Her s. 7 argument is that the provisions infringe her liberty and security interests and are contrary to the principles of fundamental justice because the inability of those under 16 to prove capacity is an arbitrary restriction. She argued that if the provisions were interpreted to include a rebuttable presumption that would allow her to lead evidence demonstrating that she had sufficient maturity to make treatment decisions, they would not be arbitrary and would be in accordance with the principles of fundamental justice.

[27] A.C. further argued that the provisions violate s. 15 because they discriminate against her based on age. Again, however, she concludes that if the legislation permitted her to demonstrate that she had sufficient decisional maturity, there is no discrimination.

[28] Lastly, A.C.'s argument under s. 2(*a*) is that the provisions violate her religious convictions as a Jehovah's Witness. Once again, it is her view that the ability to lead evidence of maturity would cure any constitutional infirmity.

[29] I accept the general validity of A.C.'s assertion that there is no constitutional justification for ignoring the decision-making capacity of children under the age of 16 when they are apprehended by the state. However, I do not think that the impugned provisions, properly interpreted, call for such an approach.

[30] The question is whether the statutory scheme strikes a constitutional balance between what the law has consistently seen as an individual's fundamental right to autonomous decision-making in connection with his or her body and the law's equally persistent attempts to protect vulnerable children from harm. This requires examining the legislative scheme, the common law of medical decision-making both for adults and minors, a comparative review of international jurisprudence, and relevant social scientific and legal literature. The observations that emerge from this review will inform the constitutional analysis.

The Legislative Scheme

[31] The *Child and Family Services Act*, which defines when and how children can be brought under the care of the state, is focused on protecting the best interests of the child in accordance with defined criteria. Children are defined in s. 1(1) as those under the age of majority, which, in Manitoba, is 18 (*Age of Majority Act*, C.C.S.M. c. A7, s. 1). In any proceeding under the

Act, "a child 12 years of age or more is entitled to be advised of the proceedings and of their possible implications for the child and shall be given an opportunity to make his or her views and preferences known" to the decision-maker (s. 2(2)). Children under 12 can also have their views taken into account if a judge is satisfied that they are "able to understand the nature of the proceedings" and the judge "is of the opinion that it would not be harmful to the child" (s. 2(3)).

[32] The "best interests of the child" standard, found in s. 2(1)[1], is the conceptual cornerstone of the Act, whose preambular Declaration of Principles proclaims that "[t]he best interests of children are a fundamental responsibility of society." Section 2(1) is set out in full, with the relevant provisions underlined:

> **2(1)** The best interests of the child shall be the paramount consideration of the director, an authority, the children's advocate, an agency and a court in all proceedings under this Act affecting a child, other than proceedings to determine whether a child is in need of protection, and in determining the best interests of the child all relevant matters shall be considered, including
>
> (a) the child's opportunity to have a parent-child relationship as a wanted and needed member within a family structure;
>
> (b) the mental, emotional, physical and educational needs of the child and the appropriate care or treatment, or both, to meet such needs;
>
> (c) the child's mental, emotional and physical stage of development;
>
> (d) the child's sense of continuity and need for permanency with the least possible disruption;

[1]The Act has been amended since the hearing before this Court. Section 2(1) now states: "The best interests of the child shall be the paramount consideration of the director, an authority, the children's advocate, an agency and a court in all proceedings under this Act affecting a child, other than proceedings to determine whether a child is in need of protection, and in determining best interests the child's safety and security shall be the primary considerations. After that, all other relevant matters shall be considered, including. . . ."

(e) the merits and the risks of any plan proposed by the agency that would be caring for the child compared with the merits and the risks of the child returning to or remaining within the family;

(f) the views and preferences of the child where they can reasonably be ascertained;

(g) the effect upon the child of any delay in the final disposition of the proceedings; and

(h) the child's cultural, linguistic, racial and religious heritage.

[33] A child in need of protection is defined in s. 17(1), which states that "a child is in need of protection where the life, health or emotional well-being of the child is endangered by the act or omission of a person". Section 17(2) develops this general proposition by including a child who:

(b) is in the care, custody, control or charge of a person

. . .

(iii) who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or well-being of the child or who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner;

[34] Section 25 of the Act deals with the authorization of the medical treatment of an apprehended child, including when consent is required and what procedures should be followed. Authority is given to child protection authorities to authorize medical treatment for apprehended children in s. 25(1)(b) and (c). Under s. 25(1)(b), a medical examination can be authorized by the agency where the consent of a parent or guardian would otherwise be required. Medical or dental treatment can be authorized under s. 25(1)(c) if

(i) the treatment is recommended by a duly qualified medical practitioner or dentist,

(ii) the consent of a parent or guardian of the child would otherwise be required, and

(iii) no parent or guardian of the child is available to consent to the treatment.

[35] According to s. 25(2), where a child is 16 or over, a medical examination or treatment *cannot* be authorized without the consent of the child. Where the child is 16 or over and refuses to consent, or where the parents of a child under 16 refuse to consent, the agency may apply to a court for an order authorizing the treatment in accordance with s. 25(3), which states:

> **25(3)** An agency may apply to court for an order
>
> (a) authorizing a medical examination of an apprehended child where the child is 16 years of age or older and refuses to consent to the examination; or
>
> (b) authorizing medical or dental treatment for an apprehended child where
>
> (i) the parents or guardians of the child refuse to consent to the treatment, or
>
> (ii) the child is 16 years of age or older and refuses to consent to the treatment.

[36] Where the judge is satisfied that the life or health of the child is seriously and imminently endangered, the application can proceed without filing the necessary documents (s. 25(6)) and testimony can be given over the telephone (s. 25(7)).

[37] Sections 25(8) and 25(9) govern when a court can impose medical treatment at the request of the agency. They are the two provisions being challenged in this case and are repeated here for ease of reference:

> **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.

[38] This is the relevant statutory context. Its language and objectives frame the constitutional analysis but cannot, by themselves, provide the whole picture. As stated earlier, A.C.'s argument that ss. 25(8) and 25(9) infringe the *Charter* is grounded in the contention that they fail to respect the mature minors' "deeply rooted" right to decide their own medical care. Unlike the Chief Justice, therefore, it is my respectful view that the next step in the interpretive exercise requires examining the common law of medical decision-making generally, and then how it has been applied in the case of minors.

Common Law for Adults

[39] The legal environment for adults making medical treatment decisions is important because it demonstrates the tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity.

[40] At common law, adults are presumptively entitled to direct the course of their own medical treatment and generally must give their "informed consent" before treatment occurs, although this presumption of capacity can be rebutted by evidence to the contrary. (See Lucinda Ferguson, "The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions", paper prepared for the Law Commission of Canada (October 29, 2004), at p. 5.) When competency is not in question, this right "to decide one's own fate" (*Re T (adult: refusal of medical*

treatment), [1992] 4 All E.R. 649 (C.A.), at p. 661) includes the unqualified right to refuse life-saving medical treatment.

[41] In the leading case of *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.), a doctor was held liable for battery because he gave an unconscious adult Jehovah's Witness a blood transfusion despite the fact that she had a signed card stating clearly that she would not consent to a transfusion. Even though the treatment almost certainly saved her life, Robins J.A. cogently explained the basis for the doctor's liability as follows:

> A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment. . . . The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care.
>
> . . .
>
> To transfuse a Jehovah's Witness in the face of her explicit instructions to the contrary would, in my opinion, violate her right to control her own body and show disrespect for the religious values by which she has chosen to live her life.
>
> . . .
>
> The state's interest in preserving the life or health of a competent patient must generally give way to the patient's stronger interest in directing the course of her own life.
>
> . . .
>
> In sum, it is my view that the principal interest asserted by Mrs. Malette in this case — the interest in the freedom to reject, or refuse to consent to, intrusions of her bodily integrity – outweighs the interest of the state in the preservation of life and health and the protection of the integrity of the medical profession. While the right to decline medical treatment is not absolute or unqualified, those state interests are not in themselves sufficiently compelling to justify forcing a patient to submit to nonconsensual invasions of her person. [Emphasis added; pp. 424, 426, 429 and 430.]

[42] There is a significant exception to this principle in the case of emergencies. Robins J.A. explained why no consent is required in such circumstances as follows:

> The emergency situation is an exception to the general rule requiring a patient's prior consent. When immediate medical treatment is necessary to save the life or preserve the health of a person who, by reason of unconsciousness or extreme illness, is incapable of either giving or withholding consent, the doctor may proceed without the patient's consent. The delivery of medical services is rendered lawful in such circumstances either on the rationale that the doctor has implied consent from the patient to give emergency aid or, more accurately in my view, on the rationale that the doctor is privileged by reason of necessity in giving the aid and is not to be held liable for so doing. On either basis, in an emergency the law sets aside the requirement of consent on the assumption that the patient, as a reasonable person, would want emergency aid to be rendered if she were capable of giving instructions. [pp. 424-25]

[43] The principles set out in *Malette* were applied by the Ontario Court of Appeal in a non-religious context in *Fleming v. Reid* (1991), 4 O.R. (3d) 74, where two men with schizophrenia were declared to be incompetent to consent to psychiatric treatment. Their physician proposed to treat them with neuroleptic drugs which, for many, control or minimize psychotic episodes or symptoms associated with schizophrenia, but which can have significant and unpredictable harmful side effects. When they were competent, the two patients had expressed a desire not to take the drugs.

[44] Concluding that these preferences ought to be respected, Robins J.A. summarized the applicable law as follows:

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination.
>
> . . .

> [I]n my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive. [Emphasis added; pp. 85 and 88.]

(See also *R. v. Morgentaler*, [1988] 1 S.C.R. 30.)

[45] In *Rodriguez*, notwithstanding its conclusion on assisted suicide, this Court nonetheless confirmed that adults have the right to refuse or discontinue treatment, regardless of the results. As noted by Justice Sopinka for the majority:

> Canadian courts have recognized a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued (*Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119). This right has been specifically recognized to exist even if the withdrawal from or refusal of treatment may result in death (*Nancy B. v. Hotel Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. S.C.); and *Malette v. Shulman* . . .). [p. 598]

Common Law for Minors

[46] The latitude accorded to adults at common law to decide their own medical treatment had historically narrowed dramatically when applied to children. However the common law has more recently 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. This is known as the common law "mature minor" doctrine. As the Manitoba Law Reform Commission noted, this doctrine is "a well-known, well-accepted and workable principle which . . . raise[s] few difficulties on a day-to-day basis" (*Minors' Consent to Health Care* (1995), Report No. 91, at p. 33). The doctrine addresses

the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.

[47] A.C. argued that the mature minor doctrine means that mature children are, at common law, entitled to make *all* decisions related to their medical care, including the decision to refuse life-saving medical treatment. This literal interpretation of the "mature minor" doctrine, with respect, miscasts its actual development and application, both in Canada and abroad. It also seriously underrepresents the limits on the ability to accurately assess maturity in any given child.

[48] The "mature minor" principle was first articulated by the House of Lords in *Gillick v. West Norfolk and Wisbech Area Health Authority*, [1985] 3 All E.R. 402. The issue was whether a doctor could prescribe contraception for a girl under the age of 16 without attracting liability in tort for proceeding without the consent of her parents.

[49] The majority accepted that adolescents under the age of 16 could, theoretically, consent to medical treatment. Lord Fraser explained:

> It seems to me verging on the absurd to suggest that a girl or a boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set. Of course the consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man

> to make the examination or give the treatment which he advises. After all, a minor under the age of 16 can, within certain limits, enter into a contract. He or she can also sue and be sued, and can give evidence on oath. Moreover, a girl under 16 can give sufficiently effective consent to sexual intercourse to lead to the legal result that the man involved does not commit the crime of rape. . . . Accordingly, I am not disposed to hold now, for the first time, that a girl aged less than 16 lacks the power to give valid consent to contraceptive advice or treatment, merely on account of her age. [p. 409]

[50] While accepting that the parental right and duty of custody and control does not entirely disappear until a child reaches the age of majority, Lord Fraser observed that the imposition of a rigid legal line would fail to reflect the reality that a child's transition from childhood to adulthood is a continuous one:

> It is, in my view, contrary to the ordinary experience of mankind, at least in Western Europe in the present century, to say that a child or a young person remains in fact under the complete control of his parents until he attains the definite age of majority, now 18 in the United Kingdom, and that on attaining that age he suddenly acquires independence. In practice most wise parents relax their control gradually as the child develops and encourage him
> or her to become increasingly independent. Moreover, the degree of parental control actually exercised over a particular child does in practice vary considerably according to his understanding and intelligence and it would, in my opinion, be unrealistic for the courts not to recognise these facts. [pp. 410-11]

[51] In a separate but concurring opinion, Lord Scarman also conceived of parental authority as declining gradually in accordance with the young person's evolution into adulthood:

> . . . I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.
>
> . . . The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose on the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.
>
> . . .

> . . . parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision. [pp. 423, 421 and 422]

While accepting that assessing the sufficiency of a child's maturity created an uncertain standard, Lord Scarman, like Lord Fraser, was of the view that a level of uncertainty was worth the cost of keeping "the law in line with social experience" (p. 425).

[52] *Gillick* was hailed as ushering in an era of judicial respect for children's rights to self-determination, and it clearly made great strides in that direction. Yet it is important to remember that the issue was a child's ability to authorize treatment that a medical professional considered to be in that child's best interests. Lord Fraser's conclusion that physicians could rely on the instructions of "mature" children rested at least partly on the assumption that "there may be circumstances in which a doctor is a better judge of the medical advice and treatment which will conduce to a [child's] welfare than her parents" (p. 412 (emphasis added)). The ultimate question was always "what is best in the interests of the . . . [minor] patient" (p. 413).

[53] Even for Lord Scarman, who seemed to adopt a somewhat more enhanced view of a young person's decisional rights, the issues of autonomy and "best interests" were conflated to some degree: the question was whether the minor was capable of "exercis[ing] a wise choice in his or her own interests" (p. 423).

[54] Several years later, in *Re W (a minor) (medical treatment)*, [1992] 4 All E.R. 627, the English Court of Appeal dealt with the more complicated question of whether a court could override an adolescent's refusal of treatment in the face of great injury or even death. *Re W*, and the prior

decision in *Re R (a minor) (wardship: medical treatment)*, [1991] 4 All E.R. 177 (C.A.), definitively established that even "mature minors" were subject to the court's inherent *parens patriae* jurisdiction. This inherent jurisdiction was found by the court to be broader than the powers of a natural parent, and justified overriding the treatment wishes of even a "*Gillick*-competent" minor.[2]

[55] All three judges in *Re W* stressed, however, that while the court was theoretically empowered to authorize treatment of "*Gillick*-competent" minors under its *parens patriae* jurisdiction, the wishes and objections of a minor would necessarily factor significantly into any assessment of his or her "best interests", with the weight given to such views varying in accordance with the minor's maturity. As Balcombe L.J. stated:

> [T]here is no overriding limitation to preclude the exercise by the court of its inherent jurisdiction and the matter becomes one for the exercise by the court of its discretion. Nevertheless the discretion is not to be exercised in a moral vacuum. ... [A]s children approach the age of majority, they are increasingly able to take their own decisions concerning their medical treatment. ... Accordingly the older the child concerned the greater the weight the court should give to its wishes, certainly in the field of medical treatment. In a sense this is merely one aspect of the application of the test that the welfare of the child is the paramount consideration. It will normally be in the best interests of a child of sufficient age and understanding to make an informed decision

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[2]Lord Donaldson, M.R., in both *Re R* and *Re W* also suggested that the power of parents to authorize treatment co-existed with the child's until he or she reached the age of majority, entitling parents to consent to treatment that the child did not want, even where the child was "*Gillick*-competent". In other words, while "mature minors" can consent to treatment, and while parents cannot veto that consent, minors cannot *refuse* treatment against the wishes of their parents because the parent**s** can consent on the mature child's behalf. This theory of "concurrent consents" has provoked considerable criticism in the academic literature on the ground that it is illogical and fails to reflect the House of Lords' reasoning in *Gillick* (see, e.g., Gillian Douglas, "The Retreat from *Gillick*" (1992), 55 *Mod. L. Rev.* 569; J. Masson, "Re W: appealing from the golden cage" (1993), 5 *J. Child L.* 37; John Eekelaar, "White Coats or Flak Jackets? Doctors, Children and the Courts — Again" (1993), 109 *L.Q.Rev.* 182; Michael Freeman, "Removing rights from adolescents" (1993), 17 *Adoption & Fostering* 14; Sir James Munby, "Consent to Treatment: Children and the Incompetent Patient", in Andrew Grubb, ed., *Principles of Medical Law* (2nd ed. 2004), 205, at pp. 234-35).

> that the court should respect its integrity as a human being and not lightly override its decision on such a personal matter as medical treatment, all the more so if that treatment is invasive.
>
> . . . What I do stress is that the judge should approach the exercise of the discretion with a predilection to give effect to the child's wishes on the basis that *prima facie* that will be in his or her best interests. [Emphasis added; pp. 643-44.]

Nolan L.J. agreed that "[i]n considering the welfare of a child, the court must not only recognise but if necessary defend the right of the child, having sufficient understanding to take an informed decision, to make his or her own choice" (p. 648).

[56] *Gillick*, *Re R* and *Re W* currently represent the law for adolescents' medical decision-making capacity in the United Kingdom. What is important to note is that none of these cases asserted that a "mature minor" should be treated as an adult for all decisional treatment purposes. The Court of Appeal confirmed in *Re R* and *Re W* that a child's "*Gillick* competence" or "mature minor" status at common law will not necessarily prevent the court from overriding that child's wishes in situations where the child's life is threatened. In such cases, the court may exercise its *parens patriae* jurisdiction to authorize treatment based on an assessment of what would be most conducive to the child's welfare, with the child's views carrying increasing weight in the analysis as his or her maturity increases.

[57] To date, no court in the United Kingdom has allowed a child under 16 to refuse medical treatment that was likely to preserve the child's prospects of a normal and healthy future, either on the ground that the competence threshold had not been met (see, e.g., *Re E (a minor) (wardship: medical treatment)*, [1993] 1 F.L.R. 386 (Fam. Div.); *Re S (a minor) (consent to medical treatment)*, [1994] 2 F.L.R. 1065 (Fam. Div.); *Re L (medical treatment: Gillick competency)*, [1998] 2 F.L.R.

810 (Fam. Div.)), or because the court concluded that it had the power to override the wishes of even a "*Gillick*-competent" child (see *Re M (medical treatment: consent)*, [1999] 2 F.L.R. 1097 (Fam. Div.)).

[58] Shortly after the House of Lords' decision in *Gillick*, the "mature minor" doctrine was applied in Canada. In *J.S.C. v. Wren* (1986), 76 A.R. 115 (C.A.), a 16-year-old girl had received medical approval for a therapeutic abortion, but her parents sought an injunction to prevent it because the age of majority was 18. Based on *Gillick*, Kerans J.A. concluded that the girl was capable of consenting to the abortion on her own behalf. As in *Gillick*, however, the proposition advanced in *Wren* was not that a "mature minor" was essentially an adult for medical treatment purposes, but rather that courts must give adolescents room to exercise their autonomy to the extent that their maturity allows:

> What is the application of the principle in this case? We infer from the circumstances detailed in argument here that this expectant mother and her parents had fully discussed the ethical issues involved and, most regrettably, disagreed. We cannot infer from that disagreement that this expectant mother did not have sufficient intelligence and understanding to make up her own mind. Meanwhile, it is conceded that she is a "normal intelligent 16 year old". We infer that she did have sufficient intelligence and understanding to make up her own mind and did so. At her age and level of understanding, the law is that she is to be permitted to do so.
>
> . . .
>
> . . . Parental rights (and obligations) clearly do exist and they do not wholly disappear until the age of majority. The modern law, however, is that <u>the courts will exercise increasing restraint in that regard as a child grows to and through adolescence.</u> [Emphasis added; paras. 16 and 13.]

(See also *Van Mol (Guardian ad Litem of) v. Ashmore*, 1999 BCCA 6, 168 D.L.R. (4th) 637.)

[59] As in the United Kingdom, where deferring to the wishes of a child under 16 was likely to jeopardize his or her potential for a healthy future, treatment has always been ordered by courts in Canada over the refusal of the adolescent and his or her parents. In *H. (T.) v. Children's Aid Society of Metropolitan Toronto* (1996), 138 D.L.R. (4th) 144 (Ont. Ct. (Gen. Div.)), the 13-year-old patient suffered from aplastic anaemia. She and her mother, both Jehovah's Witnesses, refused to consent to any treatment involving blood products. The two treating physicians, as well as a child psychiatrist, testified that the girl lacked the maturity to judge the foreseeable consequences of her decision. She was found not "capable of expression of refusal of consent" and therefore made a temporary ward of the state so that she could be treated.

[60] In *Dueck (Re)* (1999), 171 D.L.R. (4th) 761 (Sask. Q.B.), a 13-year-old boy refused to consent to further chemotherapy and surgery of his leg. Rothery J. found that he was not capable of refusing consent because he was deeply influenced by his father, whom he always obeyed without question. The father controlled the information the boy was getting about treatment, and misled him with respect to the nature of his condition, the treatment proposed, and the likelihood that the non-medical alternative therapies the father preferred would be successful. The boy's decision to refuse treatment was therefore found not to be voluntary, and the court ordered that he receive the treatments.

[61] In *Alberta (Director of Child Welfare) v. H. (B.),* 2002 ABPC 39, [2002] 11 W.W.R. 752, a 16-year-old girl was diagnosed with acute myeloid leukemia. The recommended course of treatment was intense chemotherapy, which would require the use of blood products. Such treatment had a success rate of 40-50 percent, which increased to 50-65 percent if accompanied by

a bone marrow transplant. The girl and her parents, Jehovah's Witnesses, refused to consent to the use of blood products. The father later changed his mind and consented, but the hospital and physicians would not treat the girl over her own refusal, since they were of the view that she was a mature adolescent and therefore entitled to refuse treatment. The Director of Child Welfare sought an apprehension and medical treatment order. Jordan Prov. Ct. J. found that the girl was not mature enough to make the decision to die, concluding that she had

> not had the life or developmental experience which would allow her to question her faith and/or its teachings and that such experience is an essential step in arriving at a personal level of development such that she can be considered to be a mature minor who has the capacity to refuse medical treatment which is necessary to save her life. Intelligence, 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. [p. 761]

The decision was upheld at the Court of Queen's Bench, 2002 ABQB 371, [2002] 7 W.W.R. 616, aff'd 2002 ABCA 109, [2002] 7 W.W.R. 644, leave to appeal refused, [2002] 3 S.C.R. vi, on the ground that the relevant provincial legislation ousted the common law rule of mature minor and justified the court's authorizing treatment in the child's best interests. See also *Hôpital Ste-Justine v. Giron*, 2002 CanLII 34269 (QC C.S.); *U. (C.) (Next friend of) v. Alberta (Director of Child Welfare)*, 2003 ABCA 66, 13 Alta. L.R. (4th) 1.

[62] Where a child's decisional capacity to refuse treatment has been upheld, on the other hand, it has been because the court has accepted that the mature child's wishes have been consistent with his or her best interests. In *Re L.D.K.* (1985), 48 R.F.L. (2d) 164 (Ont. Prov. Ct. (Fam. Div.)), for example, the patient was a 12-year-old girl suffering from acute myeloid leukaemia. She and her parents were Jehovah's Witnesses, and refused to consent to chemotherapy that would necessitate blood transfusions. The Children's Aid Society apprehended the girl in order to compel the

treatment. Two doctors testified that the odds of a favourable outcome after treatment were relatively low (around 30 percent) and that the side effects were severe. The trial judge, Main Prov. Ct. J., accepted the girl's commitment to her religious beliefs and to fighting against any transfusion, and found that "the emotional trauma [the child] would experience" in forced treatment would outweigh the anticipated benefits (p. 169). He refused to make her a ward of the state, concluding: "[T]his child's life is equally in danger whichever path is taken, whether she is left here [in hospital] and subjected to this treatment or she is allowed to leave and be treated according to the wishes and beliefs of herself and her parents" (p. 170).

[63] In *Re A.Y.* (1993), 111 Nfld. & P.E.I.R. 91 (Nfld. S.C.), the court was faced with an application from the Director of Child Welfare to impose treatment on a 15-year-old Jehovah's Witness who had cancer. The treating doctor was of the view that the young person required blood transfusions as well as chemotherapy. The court found both that the child was mature and that it was not in his best interests to impose treatment. Wells J. noted that the treatment was less than 40 percent likely to be effective, was not "essential", and was contrary to the mature adolescent's wishes. He was not, therefore, found to be a child in need of protection and subject to the state's care. (See also *Walker (Litigation Guardian of) v. Region 2 Hospital Corp.* (1994), 116 D.L.R. (4th) 477 (N.B.C.A.)).

Other Jurisdictions

[64] Not surprisingly, the relationship between an adolescent's maturity and his or her right to "medical self-determination" has been canvassed in other jurisdictions.

[65] The Supreme Court of the United States has never commented directly on the legal rights of mature adolescents to direct their own medical care, although it has recognized that some minors possess the maturity to make certain specific constitutionally protected decisions, including the decision to have an abortion (see, e.g., *Planned Parenthood of Central Missouri v. Danforth Attorney General of Missouri*, 428 U.S. 52 (1976)). In *Bellotti, Attorney General of Massachusetts v. Baird*, 443 U.S. 622 (1979), however, the court indicated that adolescents' constitutional rights could not "be equated with those of adults" (at p. 634) due to "the particular vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing" (p. 634). Neglecting to draw a clear distinction between incompetent younger children and older adolescents, the Supreme Court in *Parham, Commissioner, Department of Human Resources of Georgia v. J. R.*, 442 U.S. 584 (1979), held that "[m]ost children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment" (p. 603).

[66] Individual states have approached the issue of adolescent decision-making in various ways, some enacting statutory exceptions to the default presumption of incapacity, and some embracing the common law "mature minor" doctrine to varying degrees. As in the U.K. and Canada, no state court has gone so far as to suggest that the "mature minor" doctrine effectively "reclassifies" mature adolescents as adults for medical treatment purposes. The variance in the jurisprudence from the different states is captured in some of the following cases and academic writing: *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987); *Belcher v. Charleston Area Medical Center*, 422 S.E.2d

827 (W. Va. 1992); *In re E.G.*, 549 N.E. 2d 322 (Ill. 1989); *In the Matter of Long Island Jewish Medical Center*, 557 N.Y.S.2d 239 (Sup. Ct. 1990); *Novak v. Cobb County- Kennestone Hospital Authority*, 849 F.Supp. 1559 (N.D. Ga. 1994), aff'd 74 F.3d 1173 (11th Cir. 1996); *In the Matter of Rena*, 705 N.E.2d 1155 (Mass. 1999); *Commonwealth v. Nixon*, 761 A.2d 1151 (Pa. 2000). See also Rhonda Gay Hartman, "Coming of Age: Devising Legislation for Adolescent Decision-Making" (2002), 28 *Am. J. L. & Med.* 409; Johnathan F. Will, "My God My Choice: The Mature Minor Doctrine and Adolescent Refusal of Life-Saving or Sustaining Medical Treatment Based Upon Religious Beliefs" (2005-2006), 22 *J. Contemp. Health L. & Pol'y* 233; Elizabeth S. Scott, "The Legal Construction of Adolescence" (2000-2001), 29 *Hofstra L. Rev.* 547; Jennifer L. Rosato, "Let's Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making" (2001-2002), 51 *DePaul L. Rev.* 769).

[67] Australian courts too have recognized the "mature minor" rule. In *Secretary, Department of Health and Community Services v. J.W.B. (Marion's Case)* (1992), 175 C.L.R. 218, the High Court of Australia stated:

> The common law in Australia has been uncertain as to whether minors under sixteen can consent to medical treatment in any circumstances. However, the recent House of Lords decision in *Gillick v. West Norfolk A.H.A.* is of persuasive authority. The proposition endorsed by the majority in that case was that parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and that this
>
> rate of development depends on the individual child. . . . A minor is, according to this principle, capable of giving informed consent when he or she "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".
>
> This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law. [p. 237]

[68] And, as elsewhere, Australian courts have determined that their authority to make orders in respect of children's welfare, including medical treatment, is not limited by the decisions of a "*Gillick*-competent" minor (see *Director-General, New South Wales Department of Community Services v. Y.*, [1999] NSWSC 644, at paras. 99-103). The treatment decisions of even mature children can therefore be overridden by a court exercising its *parens patriae* jurisdiction or the Family Court's almost identical statutory jurisdiction. In *Minister for Health v. A.S.*, [2004] WASC 286, 33 Fam. L.R. 223, for example, the Supreme Court of Western Australia stated that the court will almost always override a child's decision to refuse life-saving or life-prolonging treatment, in accordance with the child's best interests. While the views of the child are relevant to the "best interests" analysis, and while a court will exercise great caution in overturning them, these wishes alone will not be determinative, regardless of maturity (para. 23; *Marion's Case*, at p. 280).

[69] What 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.

Academic Literature

[70] This reluctance to interpret the "mature minor" doctrine as demanding automatic judicial deference to the young person's medical treatment decisions where doing so will put the

adolescent's life or health in grave danger seems to stem from the difficulty of determining with any certainty whether a given adolescent is, in fact, sufficiently mature to make a particular decision. As academic legal and social scientific literature in this area reveals, there is no simple and straightforward means of definitively evaluating — or discounting — the myriad of subtle factors that may affect an adolescent's ability to make mature, stable and independent choices in the medical treatment context.

[71] There is considerable support for the notion that while many adolescents may have the technical ability to make complex decisions, this does not always mean they will have the necessary maturity and independence of judgment to make truly autonomous choices. As Jane Fortin significantly observes: ". . . cognitive capacity to reach decisions does not necessarily correlate with 'mature' judgment" (*Children's Rights and the Developing Law* (2nd ed. 2003), at p. 73). (See also Lucinda Ferguson, "Trial by Proxy: How Section 15 of the *Charter* Removes Age from Adolescence" (2005), 4 *J. L. & Equality* 84, at pp. 84 and 92; Lois A. Weithorn and Susan B. Campbell, "The Competency of Children and Adolescents to Make Informed Treatment Decisions" (1982), 53 *Child Dev.* 1589; Catherine C. Lewis, "A Comparison of Minors' and Adults' Pregnancy Decisions" (1980), 50 *Am. J. Orthopsychiatry* 446; Bruce Ambuel and Julian Rappaport, "Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion" (1992), 16 *Law & Hum. Behav.* 129; Lainie Friedman Ross, "Health Care Decisionmaking by Children: Is It in Their Best Interest?", in Michael Freeman, ed., *Children, Medicine and the Law* (2005), 487, at pp. 488-89; Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (1989), at p. 221: "[C]hildren may give inadequate weight to the effects of decisions on their future interests, and also fail to anticipate

future changes in their values that may be predictable by others".)

[72] Margaret Brazier and Caroline Bridge explore the limits of assessing autonomy in "Coercion or caring: analysing adolescent autonomy" in *Children, Medicine and the Law*, 461, in the context of whether "a teenager brought up in a Jehovah's Witness family [can] make a free choice on a matter central to his family's faith" (p. 468). They propose the following as a model for autonomous choices:

> . . . fully autonomous choice is largely an ideal. . . . The best we can manage is a maximally autonomous choice. In determining whether a particular individual choice demands respect we should look to see whether that choice is undermined by any irremediable defect in the autonomy of the choice in question. [p. 468]

[73] Many experts suggest that due to the very nature of adolescence, adolescent choices may be particularly prone to defects in decisional autonomy. Saul Levine, in his discussion of adolescent decision-making in the health care context, concludes that the influences on a minor's capacity to *independently* address and answer crucial health care decisions may be subtle but "profound":

> The minors may be competent according to the . . . developmental and cognitive criteria, and yet their relationship with their parents or with surrogates may be complicated and convoluted. Many children do not wish to counter their parents' wishes for fear of hurting them, of losing favor with them, or of engendering feelings of guilt in themselves. Other children and adolescents have a propensity to counter their parents' motivation, because they are in a rebellious phase or mode, or because of deep-seated conflict in the family. This does not do justice to the wide range of possible psychodynamic configurations. . . .
>
> ("Informed Consent of Minors in Crucial and Critical Health Care Decisions", in Aaron H. Esman, ed., *Adolescent Psychiatry: The Annals of the American Society for Adolescent Psychiatry* (2000), vol. 25, 203, at p. 211)

According to Levine, an adolescent's decisions may also be particularly affected by social opinion:

> The issue of what "they" will think, feel, or say varies with the attitudes and

> biases prevalent at the time and cannot be underestimated in its power on a child's rationale. "They" could refer to the society as a whole, but, much more so, it is related for the child to his or her local subgroup (nuclear and extended family, church congregation, close family, friends, etc.). [p. 212]

[74] Brazier and Bridge express similar concerns about the potential influence of such external factors on a child's ability to make truly independent choices:

> A child of 14 living in a deeply religious home is constrained not just by love and affection for his family but by a continuing relationship of dependency and the limited opportunity he has enjoyed to widen his horizons. [p. 486]

[75] Priscilla Alderson studied decision-making in 8- to 15-year-old London students in order to assess their degree of independence from their parents in light of the *Gillick* decision ("Everyday and medical life choices: decision-making among 8- to 15-year-old school students", in *Children, Medicine and the Law*, p. 445). She found that children were more likely to agree with their parents over having surgery or visiting a doctor than over other decisions, such as what films to watch or friends to spend time with. Alderson also conducted interviews with young people in hospitals. When asked when they thought they would be entitled to consent to surgery, most simply cited the relevant law:

> Replies on consent to surgery are probably influenced by beliefs about the law, rather than by personal preferences. A frequent reply in the hospital study is, "I'm not allowed to consent to surgery until I'm 16, or 18 or [occasionally] 21". Another response is to equate freedom to make medical decisions with being somehow "grown-up", such as old enough to go out to work or to leave home. "Sixteen" or "18" are therefore common answers, and reveal more about public beliefs than particular youngsters' need or ability. [p. 457]

[76] In a separate paper, Alderson argued that social context has a strong influence on children's competency to consent to medical treatment:

> Many factors surround children's consent, and powerfully, often invisibly, influence the child's understanding and decisions. Some of the young patients we met wanted to 'be the main decider', others wanted to share in decisions, and others wanted their parents and/or doctors to make decisions for them. Competence is more than a skill, it is a way of relating, and can be understood more clearly when each child's inner qualities are seen within a network of relationships and cultural influences.
>
> ("In the genes or in the stars? Children's competence to consent", in *Children, Medicine and the Law*, 549, at p. 553)

[77] Moreover, the health or medical status of the adolescent may in itself affect his or her maturity and ability to make maximally autonomous choices, since the ability of an adolescent to provide informed consent may be affected by the chronicity of the illness and by any "discomfort, pain, and malaise" experienced by the young person as a result of his or her condition (Levine, at p. 209).

[78] Clearly the factors that may affect an adolescent's ability to exercise *independent*, mature judgment in making maximally autonomous choices are numerous, complex, and difficult to enumerate with any precision. They include "the individual physical, intellectual and psychological maturity of the minor, the minor's lifestyle ... [and] the nature of the parent-child relationship" (Manitoba Law Reform Commission, *Minors' Consent to Health Care*, p. 32). While it may be relatively easy to test cognitive competence alone, as the social scientific literature shows, it will inevitably be a far more challenging exercise to evaluate the impact of these other types of factors.

[79] The difficulty and uncertainty involved in assessing maturity has prompted some experts to suggest that children should be entitled to exercise their autonomy only insofar as

it does not threaten their life or health. As John Eekelaar remarks:

> We cannot know for certain whether, retrospectively, a person may not regret that some control was not exercised over his immature judgment by persons with greater experience. But could we not say that it is on balance better to subject all persons to this potential inhibition up to a defined age, in case the failure to exercise the restraint unduly prejudices a person's basic or developmental interests?
>
> ("The Emergence of Children's Rights" (1986), 6 *Oxford J. Legal Stud.* 161, at pp. 181-82)

(See also Michael D. A. Freeman, *The Rights and Wrongs of Children* (1983), ch. 2; and Fortin, at p. 76).

Interpreting Best Interests

[80] These observations take us back to ss. 25(8) and 25(9) of the *Child and Family Services Act*, and to an interpretive approach to "best interests" that is consistent with international standards, developments in the common law, and the reality of childhood and child protection.

[81] The general purpose of the "best interests" standard is to provide courts with a focus and perspective through which to act on behalf of those who are vulnerable. In contrast, competent adults are assumed to be "the best arbiter[s] of [their] own moral destiny" (Giles R. Scofield, "Is the Medical Ethicist an 'Expert'?" (1994), 3(1) *Bioethics Bulletin* 1, at p. 2), 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.

[82] The application of an objective "best interests" standard to infants and very young children is uncontroversial. Mature adolescents, on the other hand, have strong claims to autonomy, but these claims exist in tension with a protective duty on the part of the state that is also justified.

[83] The tension between autonomy and child protection is real, often dramatic, and always painful. It is described by Joan M. Gilmour as follows:

> While a mature minor can consent to medically recommended treatment, the extent to which he or she has the power to consent to a treatment that is not beneficial or therapeutic remains unclear. The argument that a minor can only consent to care that would be of benefit (or refuse that which is of little or no benefit) is sometimes referred to as "the welfare principle". It suggests that a mature minor can only make those decisions about medical care that others would consider to be in his or her interests; as such, it challenges the extent of the commitment in law to mature minors' interests in self-determination and autonomy. . . .
>
> . . . [The welfare principle] reflects an uneasiness with autonomy as the overriding value that the law advances in this context, rather than protection of the minor's life and health as one who is still vulnerable.
>
> ("Death and Dying", in Mary Jane Dykeman et al., eds., *Canadian Health Law Practice Manual* (loose-leaf), 8.01, at paras. 8.52-8.54)

[84] In my view, any solution to this tension must be responsive to its complexity. As Gilmour points out, and as the English Court of Appeal in *Re W* confirmed, the distinction between principles of welfare and autonomy 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" (para. 8.54). (See also Joan M. Gilmour, "Death, Dying and Decision-making about End of

Life Care", in Jocelyn Downie, Timothy Caufield and Colleen M. Flood, eds., *Canadian Health Law and Policy* (3rd ed. 2007) 437, at p. 443.)

[85] In the vast majority of situations where the medical treatment of a minor is at issue, his or her life or health will not be gravely endangered by the outcome of any particular treatment decision. That is why courts have determined that medical practitioners should generally be free to rely on the instructions of a young person who seems to demonstrate sufficient maturity to direct the course of his or her medical care.

[86] Where a young person comes before the court under s. 25 of the *Child and Family Services Act*, on the other hand, it means that child protective services have concluded that medical treatment is necessary to protect his or her life or health, and either the child or the child's parents have refused to consent. 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.

[87] 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.

[88] As L'Heureux-Dubé J. said in *Young v. Young*, [1993] 4 S.C.R. 3, "courts must be directed to create or support the conditions which are most conducive to the flourishing of the child" (p. 65 (emphasis added)). And in *King v. Low*, [1985] 1 S.C.R. 87, McIntyre J. observed: "It must be the aim of the Court . . . to choose the course which will best provide for the healthy growth, development and education of the child so that he will be equipped to face the problems of life as a mature adult" (p. 101 (emphasis added)). When applied to adolescents, therefore, the "best interests" standard must be interpreted in a way that reflects and addresses an adolescent's evolving capacities for autonomous decision-making. It is not only an option for the court to treat the child's views as an increasingly determinative factor as his or her maturity increases, it is, by definition, in a child's best interests to respect and promote his or her autonomy to the extent that his or her maturity dictates. (See John Eekelaar, "The Importance of Thinking

that Children Have Rights" (1992), 6 *Int'l J.L. & Fam.* 221, at pp. 228-29, and "The Interests of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism" (1994), 8 *Int'l J.L. & Fam.* 42.)

[89] This approach to "best interests" finds support in the relevant provisions of the *Child and Family Services Act.* The standard a judge is obliged to follow before deciding whether to authorize treatment for a child under 16 in accordance with s. 25(8) is found in s. 2(1) of the Act. That section sets out the primacy of the child's best interests and delineates a number of considerations to be included in making such a determination. These considerations include the mental, emotional and physical needs of the child; his or her mental, emotional and physical stage of development; the child's views and preferences; and the child's religious heritage. No priority is given to one factor over the other.

[90] What the blending of these factors will actually yield in any particular case will obviously depend on the particular child and the particular circumstances of that child. That is because the best interests standard is necessarily individualistic. As Lorne Rozovsky points out,

> it is quite possible for a particular child to be able to consent to one treatment but not another because of the child's ability to understand one and not the other. Similarly, one child may be able to consent to a particular treatment, whereas another child of the same age may not because of the difference in the mental capabilities of the two children, or because of their individual circumstances.
>
> (*The Canadian Law of Consent to Treatment* (3rd ed. 2003), at p. 83)

[91] Yet this does not mean, as Kaufman J. in this case seemed to suggest, that the standard is a licence for the indiscriminate application of judicial discretion. To divorce the application of the best interests standard from an assessment of the mature child's interest in advancing his or her own autonomous claims would be to endorse a narrow, static and

profoundly unrealistic image of the child and of adolescence.

[92] The statutory factors reflect decades of careful study into children's needs and how the law can best meet them. We have come, with time, to understand the significance of so many relevant considerations which had been previously hidden behind formulaic solutions like "the tender years doctrine". With our evolving understanding has come the recognition that the quality of decision-making about a child is enhanced by input from that child. The extent to which that input affects the "best interests" assessment is as variable as the child's circumstances, but one thing that can be said with certainty is that the input becomes increasingly determinative as the child matures. This is true not only when considering the child's best interests in the placement context, but also when deciding whether to accede to a child's wishes in medical treatment situations.

[93] Such a robust conception of the "best interests of the child" standard is also consistent with international instruments to which Canada is a signatory. The *Convention on the Rights of the Child*, Can. T.S. No. 3, which Canada signed on May 28, 1990 and ratified on December 13, 1991 describes "the best interests of the child" as a primary consideration in all actions concerning children (Article 3). It then sets out a framework under which the child's own input will inform the content of the "best interests" standard, with the weight accorded to these views increasing in relation to the child's developing maturity. Articles 5 and 14 of the Convention, for example, require State Parties to respect the responsibilities, rights and duties of parents to provide direction to the child in exercising his or her rights under the Convention, "in a manner consistent with the evolving capacities of the child".

Similarly, Article 12 requires State Parties to "assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child"(see also the Council of Europe's *Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*, E.T.S. No. 164, ch. II, art. 6: "The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity").

[94] Scrutiny of a child's maturity in a s. 25(8) best interests analysis will require, by definition, an individualized assessment, having regard to the unique situation of the particular child, including the nature of the treatment decision and the severity of its potential consequences. In *Medico-Legal Aspects of Reproduction and Parenthood* (2nd ed. 1998), J. K. Mason explains:

> I suggest that the degree of understanding required for valid consent to a doctor's advice is different from that needed to refuse to accept an opinion based on years of study and experience. In so saying, I do not deny that a child may, at times, be fully capable of a reasonable refusal of treatment — a refusal which may well be based on considerations other than medical; what I am proposing is that the level of required understanding may be higher in the latter than in the former circumstance. In any event, this is a stance the courts are not afraid to adopt when necessary. [Emphasis deleted; p. 321.]

(See Caroline Bridge, "Religious Beliefs and Teenage Refusal of Medical Treatment" (1999), 62 *Mod. L. Rev.* 585, at p. 590; Gilmour, "Death, Dying and Decision-making about End of Life Care", at p. 443; Barney Sneiderman, John C. Irvine and Philip Osborne, *Canadian Medical Law* (2003), ch. 20, "The Mature Minor Patient and the Refusal of Treatment", at

p. 465).

[95] In those most serious of cases, where a refusal of treatment carries a significant risk of death or permanent physical or mental impairment, a careful and comprehensive evaluation of the maturity of the adolescent will necessarily have to be undertaken to determine whether his or her decision is a genuinely independent one, reflecting a real understanding and appreciation of the decision and its potential consequences.

[96] As all of this demonstrates, the evolutionary and contextual character of maturity makes it difficult to define, let alone definitively identify. Yet the right of mature adolescents not to be unfairly deprived of their medical decision-making autonomy means that the assessment must be undertaken with respect and rigour. The following factors may be of assistance:

- 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?

This list is not intended to represent a formulaic approach. Its objective is to assist courts in assessing the extent to which a child's wishes reflect true, stable and independent choices.

Constitutional Diagnosis

[97] Constitutional compliance in the context of the medical treatment decisions anticipated by ss. 25(8) and 25(9) means that the best interests standard must be interpreted in a way that is not arbitrary (to avoid violating s. 7 of the *Charter*); not discriminatory on the basis of age (to avoid a s. 15 violation); and not contrary to a child's right to freedom of religion protected by s. 2(*a*). A.C. argued that all such constitutional violations can be avoided by allowing someone in her position to attempt to demonstrate sufficient maturity to have her treatment wishes respected.

[98] In my view, this is exactly what the best interests standard requires in medical treatment decision cases for adolescents. When the "best interests" standard is applied in a way that takes into increasingly serious account the young person's views in accordance with

his or her maturity in a given treatment case, the legislative scheme created by ss. 25(8) and 25(9) of the *Child and Family Services Act* is neither arbitrary, discriminatory, nor violative of religious freedom.

[99] We turn first to whether ss. 25(8) and 25(9) of the *Child and Family Services Act*, as interpreted in these reasons, violate A.C.'s rights under s. 7 of the *Charter*.

[100] An order imposing medical treatment under s. 25 implicates a child's liberty and security of the person. Wilson J., in *Morgentaler*, stated that "[liberty], properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance" (p. 166; see also *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307, at para. 49: "'liberty' is engaged where state compulsions or prohibitions affect important and fundamental life choices"; *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844, at para. 66: "[T]he right to liberty ... protects within its ambit the right to an irreducible sphere of personal autonomy wherein individuals may make inherently private choices free from state interference"). And in *Rodriguez*, Sopinka J. for the majority confirmed that the concept of security of the person encompasses "a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress" (pp. 587-88). As McLachlin J. explained in dissent:

> Security of the person has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body. This is in accordance with the fact ... that "s. 7 was enacted for the purpose of ensuring human dignity

and individual control, so long as it harms no one else". [p. 618]

(See also *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123, at p. 1177: "Section 7 is . . . implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity").

[101] The notion that ss. 25(8) and 25(9) engage A.C.'s security of the person and liberty interests also finds support in the common law, which, as shown earlier in these reasons, has long recognized "[t]he right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment" (*Fleming*, at p. 85). The principle was adopted by this Court in *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, at p. 135, where Cory J. explained:

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. If, during the course of a medical procedure a patient withdraws the consent to that procedure, then the doctors must halt the process. This duty to stop does no more than recognize every individual's basic right to make decisions concerning his or her own body.

[102] The inability of an adolescent to determine her own medical treatment, therefore, constitutes a deprivation of liberty and security of the person, which must, to be constitutional, be in accordance with the principles of fundamental justice (G. Dworkin, "Consent, Representation, and Proxy Consent," in W. Gaylin and R. Macklin, eds., *Who Speaks For The Child: The Problems of Proxy Consent* (1982), 191, at p. 203).

[103] A.C. argued that if the provisions are interpreted narrowly so that someone under 16 is deprived of the opportunity to demonstrate her capacity, they are arbitrary, and a law that is arbitrary will not be in accordance with the principles of fundamental justice (*Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791, at paras. 129-31, citing *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571, at para. 135, and *Rodriguez*, at p. 594). As the Chief Justice and Major J. explained in *Chaoulli*: "The state is not entitled to arbitrarily limit its citizens' rights to life, liberty and security of the person" (para. 129). A law will be arbitrary

> where "it bears no relation to, or is inconsistent with, the objective that lies behind [it]". To determine whether this is the case, it is necessary to consider the state interest and societal concerns that the provision is meant to reflect: *Rodriguez*, at pp. 594-95.
>
> In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection. Where the individual's very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals. [Emphasis added; paras. 130-31.]

[104] It is therefore necessary to put the analysis into the context of the objectives of the provisions. The overarching goal of statutes such as the *Child and Family Services Act* is to protect children from harm (*Winnipeg Child and Family Services v. K.L.W.*, 2000 SCC 48, [2000] 2 S.C.R. 519, at para. 15; *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315, at p. 382; *Syl Apps Secure Treatment Centre v. B.D.*, 2007 SCC 38, [2007] 3 S.C.R. 83, at para. 2). In *B. (R.)*, La Forest J. discussed the importance of the

state's role in protecting children:

> The state's interest in legislating in matters affecting children has a long-standing history. In *R. v. Jones*, *supra*, for example, I acknowledged the compelling interest of the province in maintaining the quality of education. More particularly, the common law has long recognized the power of the state to intervene to protect children whose lives are in jeopardy and to promote their well-being, basing such intervention on its *parens patriae* jurisdiction; see, for example, *Hepton v. Maat*, *supra*; *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388. The protection of a child's right to life and to health, when it becomes necessary to do so, is a basic tenet of our legal system, and legislation to that end accords with the principles of fundamental justice, so long, of course, as it also meets the requirements of fair procedure. [Emphasis added; para. 88.]

(See also *R. v. Sharpe*, 2001 SCC 2, [2001] 1 S.C.R. 45, at para. 174.) And this Court has long recognized that children are a "highly vulnerable" group (*Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, 2004 SCC 4, [2004] 1 S.C.R. 76, at para. 56; *R v. D.B.*, 2008 SCC 25, [2008] 2 S.C.R. 3, at para. 48).

[105] On the other hand, adolescents clearly have an interest in exercising their capacity for autonomous choice to the extent that their maturity allows. And society has a corresponding interest in nurturing children's potential for autonomy by according weight to their choices in a manner that is reflective of their evolving maturity. In order to promote this objective, "paternalism should always be kept to a minimum and carefully justified" (Fortin, at p. 26).

[106] Given these competing values, a problem arises when a child's interest in exercising his or her autonomy conflicts with society's legitimate interest in protecting him or her from harm. As Fortin remarks: "The difficulty lies in establishing a formula which authorizes paternalistic interventions to protect adolescents from making life-threatening

mistakes, but restrains autocratic and arbitrary adult restrictions on their potential for autonomy" (pp. 26-27).

[107] Given the significance we attach to bodily integrity, it would be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions. It is not, however, arbitrary to give them the opportunity to prove that they have sufficient maturity to do so.

[108] Interpreting the best interests standard so that a young person is afforded a degree of bodily autonomy and integrity commensurate with his or her maturity navigates the tension between an adolescent's increasing entitlement to autonomy as he or she matures and society's interest in ensuring that young people who are vulnerable are protected from harm. This brings the "best interests" standard in s. 25(8) in line with the evolution of the common law and with international principles, and therefore strikes what seems to me to be an appropriate balance between achieving the legislative protective goal while at the same time respecting the right of mature adolescents to participate meaningfully in decisions relating to their medical treatment. The balance is thus achieved between autonomy and protection, and the provisions are, accordingly, not arbitrary.

[109] A.C. also argued that s. 25(8) violated her s. 15 equality rights on the basis of age. In *R. v. Kapp*, 2008 SCC 41, [2008] 2 S.C.R. 483, the Court confirmed that the applicable two-part test under s. 15(1) is:

> (1) Does the law create a distinction based on an enumerated or analogous

> ground? (2) Does the distinction create a disadvantage by perpetuating prejudice or stereotyping? [para. 17]

[110] Age distinctions have frequently been upheld by this Court (see *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497; *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84, [2002] 4 S.C.R. 429; *McKinney v. University of Guelph*, [1990] 3 S.C.R. 229; *Harrison v. University of British Columbia*, [1990] 3 S.C.R. 451; *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483; and *Douglas/Kwantlen Faculty Assn. v. Douglas College*, [1990] 3 S.C.R. 570). (But see *Tétreault-Gadoury v. Canada (Employment and Immigration Commission)*, [1991] 2 S.C.R. 22.) They are currently employed to determine when a person can marry, vote, drive, consent to sexual intercourse and sell property. As noted by McLachlin C.J. in *Gosselin*, it must be recognized that "age-based legislative distinctions are a common and necessary way of ordering our society" (para. 31). In the context of s. 15 of the *Charter*, McLachlin C.J. has commented that while "all age-based distinctions have an element of this literal kind of 'arbitrariness'," this alone does not invalidate them "[p]rovided that the age chosen is reasonably related to the legislative goal" (*Gosselin*, at para. 57).

[111] Age demarcations for allocating presumptions were defended by Jessica W. Berg et al., in *Informed Consent: Legal Theory and Clinical Practice* (2nd ed. 2001):

> Most authors in this area agree that age cut-offs should not be used as automatic determinants of de facto capacity for any type of decision but <u>may function as an indicator to shift presumptions</u>. Thus, individuals below the age of consent are presumed to lack capacity unless shown otherwise, and those above the age of consent are presumed to have capacity until shown otherwise. [Emphasis added; p. 97.]

Under the *Child and Family Services Act*, the distinction between promoting autonomy and protecting welfare is presumed to collapse at age 16, subject to evidence to the contrary. But whether a child is under or over 16, the weight that is accorded to his or her views under s. 25 of the Act will ultimately correspond to a court's conclusions about the extent to which the child is capable of making decisions in his or her own best interests. By permitting adolescents under 16 to lead evidence of sufficient maturity to determine their medical choices, their ability to make treatment decisions is ultimately calibrated in accordance with maturity, not age, and no disadvantaging prejudice or stereotype based on age can be said to be engaged. There is therefore no violation of s. 15.

[112] A.C. also alleged that her freedom of religion was infringed because the Act prevented her from refusing medical treatment that is contrary to her religious beliefs. She contends that the legislative scheme in the *Child and Family Services Act* avoids infringing her s. 2(*a*) rights only if she is entitled to lead evidence of sufficient maturity.

[113] This is precisely the effect of interpreting the "best interests" test in s. 25(8) as an evolutionary compendium of considerations that give increased strength to increased maturity. Moreover, consideration of a child's "religious heritage" is one of the statutory factors in determining "best interests". Expanding the deference to a young person's religious wishes as her maturity increases is a proportionate response to her religious rights and the protective goals of s. 25(8).

[114] 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.

[115] 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. This, in my view, 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.

[116] 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. However, this is not the effect of ss. 25(8) and 25(9). As the foregoing analysis demonstrates, a child's maturity and corresponding interest in self-determination will

factor significantly into any determination of his or her "best interests" under s. 25(8) of the Act, with the child's views becoming increasingly determinative as his or her maturity increases.

[117] I would therefore uphold the constitutionality of ss. 25(8) and 25(9) of the *Child and Family Services Act*.

[118] Having determined that ss. 25(8) and 25(9) of the Act are constitutional, the final question is what this means for the present case. A.C. sought an order setting aside Kaufman J.'s treatment order on the basis that she was a mature minor and that her treatment decisions therefore ought to have been respected.

[119] No one in any of the proceedings determined whether A.C. was in fact able to make a mature, independent judgment about her medical treatment, and the psychiatric report was never subjected to a review of any kind, let alone a searching one. Kaufman J. proceeded based on his view that the question of A.C.'s capacity was ultimately irrelevant under the Act, concluding that when a child is under 16, there are no restrictions on the court's ability to authorize medical treatment on his or her behalf. At the Court of Appeal, the question of A.C.'s capacity was not even considered by the court. In response to the Attorney General of Manitoba's argument that the appeal should not be heard because there was no proper evidentiary record of capacity, Steel J.A. stated:

> I agree that the determination of capacity is a delicate issue heavily dependant on the facts. However, it is not necessary to decide the issue of capacity in order to address the legal issue raised in this appeal. The issue is

> strictly one of statutory interpretation and, depending on the meaning given to the legislation, whether the legislation conforms with the requirements of the *Charter*. [Emphasis added; para. 37.]

[120] Since neither court in the prior proceedings assessed A.C.'s "best interests" in light of her maturity, there is no reviewable judicial determination before us as to A.C.'s ability to make an independent, mature decision to refuse the blood transfusions, in accordance with the intense scrutiny contemplated in these reasons for such circumstances. Moreover, the issue of the validity of Kaufman J.'s treatment order is clearly moot — the medical emergency that gave rise to this litigation is long since over and A.C. is no longer under the age of 16.

[121] On the other hand, while A.C. has technically lost her constitutional challenge, she successfully argued that the provisions should be interpreted in a way that allows an adolescent under the age of 16 to demonstrate sufficient maturity to have a particular medical treatment decision respected. In these circumstances, it seems to me appropriate that since this is the major impact of these reasons, she should be awarded her costs.

[122] Accordingly, although the appeal from the Court of Appeal's finding of constitutionality is dismissed, A.C. is entitled to her costs throughout.

The reasons of McLachlin C.J. and Rothstein J. were delivered by

[123] THE CHIEF JUSTICE — I agree with Abella J. that s. 25(8) of the *Child and Family Services Act* C.C.S.M. c. C80 ("CFSA"), does not violate the *Canadian Charter of Rights and*

Freedoms, and that the applications judge's decision in this case should be upheld. In my view, this conclusion follows from a consideration of what the statute requires and the settled law on ss. 2(*a*), 7 and 15 of the *Charter*. The *CFSA* provides a complete statutory scheme with respect to medical decisions for children and adolescents deemed to be in need of state protection. This comprehensive scheme displaces the existing common law regarding medical decision-making by "mature minors". In my view, the constitutional analysis must therefore center on the statute itself.

1. The *CFSA* Displaces the Common Law "Mature Minor" Doctrine

[124] The "mature minor" doctrine was developed as a means to govern the relationship between a medical professional and a minor with capacity. As Abella J. explains, the mature minor doctrine reflects a "recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding" (para. 46).

[125] The mature minor doctrine remains the relevant common law with respect to capable adolescents' consent to medical treatment. In contrast, however, the Manitoba legislature has addressed the specific child welfare concerns that arise where necessary care is refused. Section 17(2)(b) of the *CFSA* provides:

> (b) is in the care, custody, control or charge of a person
>
> . . .
>
> (iii) who neglects or refuses to provide or obtain proper medical ... care or treatment necessary for the health or well-being of the child or who refuses

> to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner.

As Steel J.A. noted for the Court of Appeal:

> The mature minor principle focusses on the right to autonomy and independent decision-making. In child protection legislation, that principle must be balanced against the welfare principle. The state has an interest in the sanctity of life and, in particular, in preserving the life and health of the child.
>
> (2007 MBCA 9, 212 Man. R. (2d) 163, at para. 54)

It is these competing interests, particularly as they apply to younger adolescents, that the *CFSA* attempts to reconcile.

[126] As Steel J.A. observed:

> The language in s. 25(8) and (9) read together is sufficiently clear to oust the common law rule for those under 16. The legislature intended to supersede the common law and to implement a specific policy choice based upon the best interests of a child under 16 in cases where there has been a determination that a child's life or health is being endangered. Continued application of the mature minor rule in that situation would be inconsistent with the express provisions of the *CFSA*. [para. 57]

In my view, the *CFSA* provides a complete code with respect to medical decision-making for or by apprehended minors. It therefore ousts the common law regarding mature minors.

2. What the *CFSA* Provides

[127] The Manitoba *CFSA* deals with the difficult situation of providing medical care to a child in circumstances where the child (defined as anyone under 18 years of age) and his or her parents refuse to consent to treatment. The state has an interest in ensuring that children receive necessary medical care. This Court has held that "[t]he protection of a child's right to life and to health, when it becomes necessary to do so, is a basic tenet of our legal system, and legislation to that end accords with the principles of fundamental justice, so long, of course, as it also meets the requirements of fair procedure": *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315, at para. 88, *per* La Forest J.

[128] The parents or the child may, for various reasons, refuse to consent to care that is necessary to protect the child's life or health. Refusal, for whatever reason, may qualify the child as in need of protection: s. 17(2)(b)(iii). Not all refusals will result in a finding that a child is in need of protection. For instance, in *Re A.Y.* (1993), 111 Nfld. & P.E.I.R. 91, the Newfoundland Supreme Court held that a 15 year-old boy suffering from terminal cancer and refusing a transfusion on religious grounds was not "a child in need of protection" because the blood transfusion was not considered essential. Whether a child is in need of protection requires a case-by-case analysis with a view to the relevant statutory criteria as discussed more fully below.

[129] Once a child is found to be in need of protection and is apprehended pursuant to s. 21(1), ss. 25(8) and 25(9) set out the process for the judicial authorization of treatment (see Appendix). The legislation allows the court to authorize treatment that it considers to be in the best interests of the child pursuant to the criteria in s. 2(1).

[130] The *CFSA* distinguishes between "children" under 16 years of age and "children" aged 16 to 18. Section 25(8) provides that in the case of children under 16, the judge "may authorize ... any medical ... treatment that the court considers to be in the best interests of the child". In the case of children 16 and over, s. 25(9) provides that treatment cannot be ordered without the patient's consent, unless the court is satisfied that he or she is unable to understand the nature of the decision and its likely consequences. As A.C. was under 16 at the time of the order for treatment, s. 25(9) did not apply.

[131] Under both ss. 25(8) and 25(9), the judge ordering treatment must be satisfied that it is in the best interests of the child. The Act defines the "best interests of the child" in s. 2(1). Section 2(1) directs the judge to consider "all relevant matters", and goes on to set out a list of considerations that may be relevant, depending on the nature of the case. In terms of this case, the most important of these are "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"; and "the views and preferences of the child where they can reasonably be ascertained".

[132] In summary, the statute requires the judge making an order for treatment of a minor to be satisfied that the order is in the child's best interests . To determine whether it is in the child's best interests, the judge must consider all relevant circumstances, including the child's needs, mental and emotional maturity and preferences. The judge must weigh the various relevant factors and on that basis arrive at a decision as to whether an order for

treatment is in the child's best interests. In the case of a child aged 16 or older, he or she has the right to refuse treatment, unless the judge is satisfied that the child is unable to understand the nature of the decision and its likely consequences.

[133] It will be apparent that the statutory scheme requires the judge in each case to make an independent analysis of all relevant considerations, including those listed in s. 2(1). For this reason, it is dangerous to speculate on whether a judge would ever, under a legislative scheme such as this, decline to order medical treatment for a child under the age of 16 where the result would be probable death. Similarly, it may be unhelpful to hypothesize on where the line between autonomy and treatment should be drawn in particular cases. 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 the full future impact of her immediate choice.

3. Is the Legislation Constitutional?

(a) *The Section 7 Challenge*

[134] A.C. argues that s. 25(8) violates s. 7 of the *Charter,* which provides that the state must not deprive a person of "life, liberty and security of the person", except in accordance with the principles of fundamental justice. A.C. contends that the treatment order by Kaufman J. infringed her liberty and security of the person. More generally, A.C. argues that

the statutory scheme, s. 25(8) in particular, deprives her of "liberty" and "security of the person" by allowing a court to order treatment against her wishes. A.C. claims that it does so in a way that is arbitrary and thus contrary to the principles of fundamental justice.

[135] Specifically, A.C. argues that the multi-factored "best interests of the child" approach required by s. 25(8) operates unconstitutionally in the case of a child under 16 who possesses the capacity to make a decision on her treatment. A.C. asserts that a child under 16 who understands the nature of the treatment and its consequences has the constitutional right to refuse treatment under s. 7 of the *Charter*. The state has no right to vest this authority in the court, in her view.

(i) Principles of Fundamental Justice

[136] It is clear that s. 25(8) deprives a child under 16 of the "liberty" to decide her medical treatment. An order for treatment of an unwilling minor may also impinge on her "security of person", which protects a person's interest in "bodily integrity": *R. v. Morgentaler*, [1988] 1 S.C.R. 30, at p. 56 (*per* Dickson C.J.).

[137] This leaves the question of whether the law infringes liberty and security of the person in a manner that is contrary to the principles of fundamental justice. This inquiry reflects the fact that the s. 7 liberty or "autonomy" right is not absolute, even for adults. In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, there was broad agreement that the s. 7 right to make decisions about one's body and life may be constrained

by law to reflect other competing societal interests. In that case, the competing societal interest was the protection of vulnerable persons who may be subject to coercion to end their life prematurely. The majority (*per* Sopinka J.) held that this balancing of interests occurs under s. 7 through the rubric of the principles of fundamental justice. I took the view (in dissent) that the competing interests should be considered under the s. 1 justification analysis. Notwithstanding these different approaches, all members of the Court who addressed the issue accepted that limits on personal autonomy that advance a genuine state interest do not violate s. 7 if they are shown to be based on rational, rather than arbitrary grounds.

[138] As Steel J.A. noted at the Court of Appeal, the principles of fundamental justice have both substantive and procedural elements: see Lamer C.J. in *New Brunswick (Minister of Health and Community Services) v. G. (J.)* , [1999] 3 S.C.R. 46, at para. 70 ("the principles of fundamental justice in child protection proceedings are both substantive and procedural"). I will consider each in turn.

(ii) Substantive Principles of Fundamental Justice

[139] A.C. argues that the distinction drawn between children under 16 and children 16 and above violates the substantive principle of fundamental justice that decisions concerning liberty not be arbitrary. Children 16 and over have the right to refuse treatment, provided they understand the treatment and appreciate the consequences of the decision to consent or not consent to treatment. Children under 16, even though they may possess the requisite understanding, do not have that right. Given that age is an inexact proxy for

decision-making capacity, A.C. contends that differential treatment based on a child's having attained the age of 16 is arbitrary for the purposes of s. 7.

[140] A limit on a s. 7 interest is arbitrary if it "bears no relation to, or is inconsistent with, the objective that lies behind the legislation": *Rodriguez*, at pp. 619-20, *per* McLachlin J., dissenting. As I stated with Major J. in *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791, "[t]he question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair" (para. 131).

[141] In order to determine whether a statutory provision is arbitrary and therefore contrary to fundamental justice, "the relationship between the provision and the state interest must be considered": Sopinka J. in *Rodriguez*, at p. 594. In the present case, the relevant statutory provisions address the circumstance where a parent or legal guardian refuses to obtain or allow necessary medical care to be provided to a child in his or her care. Where the affected adolescent also refuses care, a medical professional cannot legally administer treatment. To resolve the dilemma between adolescent autonomy and the state's interest in ensuring child welfare, the *CFSA* allows courts to authorize necessary treatment under certain conditions. The objective of the statutory scheme is to balance society's interest in ensuring that children receive necessary medical care on the one hand, with the protection of minors' autonomy interest to the extent this can be done, on the other. Sections 25(8) and 25(9), informed by s. 2(1), set up a mechanism to achieve this goal.

[142] The question is whether the impugned distinction between minors who have reached the age of 16 and those who have not is related to the legislative objective. In my view, it is.

[143] The legislative decision to vest treatment authority regarding under-16 minors in the courts is a legitimate response, in my view, to heightened concerns about younger adolescents' maturity and vulnerability to subtle and overt coercion and influence. The legislature's decision not to accord a presumption of consent to children under 16 reflects the reality that the judgment of children on momentous personal decisions increases with age. Judgment is a function, not only of intellectual understanding of treatment and the consequences of refusing it, but of experience and independence. To use the term invoked by the Director of Child and Family Services ("Director"), it requires "ethical, emotional maturity" (R.F., at para. 35). As Abella J. explains with reference to the relevant social science literature (at paras. 71-80), younger adolescents are more susceptible to the influence of their peers and parents than older adolescents. In my opinion, the legislative scheme evidences a legitimate concern with these factors as they affect younger adolescents, and the impracticability of reliably testing for them in the crucial and often exigent context of authorizing necessary medical treatment.

[144] As the Director puts it (factum, at para. 35):

> [C]apacity, however defined, is by no means the only factor governing one's ability to make an informed healthcare decision. As important is whether the choice is made *voluntarily* and whether it is, in fact, an *informed* decision:

> ... competence alone is not a sufficient condition for valid consent. ... They also need the third element of consent: voluntariness. It may be difficult to accept a treatment option if that particular choice will lead to a loss of important relationships. To give or refuse consent to medical treatment, the law requires not just decision making competence but also accurate information and lack of coercion. [Italics in original; underlining added.] Guichon, Juliet and Ian Mitchell, "Medical emergencies in children of orthodox Jehovah's Witness families: Three legal cases, ethical issues and proposals for management", *Paediatric Child Health* Vol. 11, No. 10 (December 2006), p. 657.

These concerns with free and informed decision-making animate the legislative scheme. They express the state's interest in ensuring that the momentous decision to refuse medical treatment by persons under 16 are truly free, informed and voluntary.

[145] Age, in this context, is a reasonable proxy for independence. The *CFSA* is not alone in recognizing age 16 as an appropriate marker of maturity for certain purposes. Below 16, many adolescents are physically dependent on parents for mobility (e.g. driving) and cannot work full-time. Most are also required by law to attend school. In other words, a variety of laws and social norms make them more dependent on their immediate families and peers in their daily lives than older adolescents. The danger of excessive parental and peer influence overwhelming free and voluntary choice is ever-present. Similarly, in the youth criminal law context, it is recognized as a principle of fundamental justice that young persons must generally be treated differently from adults by virtue of their "reduced maturity and moral capacity": *R. v. D.B.*, 2008 SCC 25, [2008] 2 S.C.R. 3, at para. 47 (*per* Abella J.). The *CFSA* acknowledges these realities and therefore places the final decision-making power with the courts in accordance with the best interests of the child.

[146] Against this view, my colleague Binnie J. concludes that the legislature's failure to extend full medical autonomy to children under 16 with "capacity" is arbitrary and therefore violative of s. 7. However, Binnie J. concedes that a more probing definition of "capacity" applies in the case of minors under 16. Accepting the Director's view that "capacity is about more than intelligence", he endorses (at para. 203) the Director's description of capacity as

> "ethical, emotional maturity"; in short, wisdom and a sense of judgment. Moreover, capacity, however defined, is by no means the only factor governing one's ability to make an informed healthcare decision. As important is whether the choice is made voluntarily and whether it is, in fact, an informed decision. [Emphasis deleted; R.F., at para. 35.]

The difficulty, as I see it, is that Binnie J. goes on to equate this broader definition of maturity with the more limited definition of capacity in s. 25(9) of the *CFSA*.

[147] The Director's broader definition of capacity ("ethical [and] emotional maturity") reflects the legislative concern that minors most susceptible to outside influence have their interest in truly voluntary and informed choice most carefully safeguarded. The test applicable to minors 16 and over — namely, the ability to understand the relevant information and to appreciate the reasonably foreseeable consequences of consenting or not consenting — does not capture this more robust conception of capacity. The Act requires the judge to take account of the treatment preference of a minor under 16 as a factor in assessing the child's "best interests", while refusing to give it the presumptive weight it would carry with a child aged 16 or older . This distinction reflects the societal reality of how children mature, and the dependence of children under 16 on their parents, as well as the difficulty of carrying

out a comprehensive analysis of maturity and voluntariness of the kind described by the Director in the exigent circumstances of crucial treatment decisions in cases such as A.C.'s. I conclude that the impugned distinction is not arbitrary.

(iii) Procedural Element of Principles of Fundamental Justice

[148] The s. 7 principles of fundamental justice also include a procedural dimension. Where a person's liberty or security of the person is engaged, as here, the limitation must be carried out in a procedurally fair manner. In my view, the notice and participation requirements in the *CFSA* satisfy this requirement. Section 25(4) mandates that formal notice of a treatment hearing be given to the minor in question and his or her parents or guardians, if the minor is 16 or older. But while s. 25(4) only applies to those 16 and older, the more general language in s. 2(2) guarantees that in all proceedings under the Act, "a child 12 years of age or more is entitled to be advised of the proceedings and of their possible implications for the child and shall be given an opportunity to make his or her views and preferences known to a judge or master making a decision in the proceedings". Further, s. 2(3) gives the judge a discretion to consider the views of a child under the age of 12. I agree with Steel J.A. that "[r]ead together, these provisions illustrate a considered approach by the legislature to providing age-appropriate notice to the children who may be the subject of proceedings under the *CFSA*, consistent with s. 7 of the *Charter*" (para. 84).

[149] I conclude that s. 25(8), while it impacts on the liberty and autonomy of children under 16, does so in a way that is appropriately attuned to a legitimate legislative goal. It is

not arbitrary, and therefore it does not violate s. 7 of the *Charter*.

(b) *Section 15 of the Charter*

[150] A.C. argues that the age distinction discriminates against her on the basis of age, contrary to s. 15. Under the test recently restated in *R. v. Kapp*, 2008 SCC 41, [2008] 2 S.C.R. 483, a s. 15 claimant must show that a distinction based on an enumerated or analogous ground creates a disadvantage by perpetuating prejudice or stereotyping.

[151] As this Court recognized in *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, 2004 SCC 4, [2004] 1 S.C.R. 76, "[c]hildren are a highly vulnerable group" (para. 56). Deschamps J., in dissent, further observed that "[c]hildren as a group face pre-existing disadvantage in our society. ... [T]heir vulnerability was entrenched by the traditional legal treatment of children as the property or chattel of their parents or guardians" (para. 225).

[152] In the present case, however, A.C.'s claim must fail because the distinction drawn by the Act between minors under 16 and those 16 and over is ameliorative, not invidious. First, it aims at protecting the interests of minors as a vulnerable group. Second, it protects the members of the targeted group — children under 16 — in a way that gives the individual child a degree of input into the ultimate decision on treatment. In my view, this is sufficient to demonstrate that the distinction drawn by the Act, while based on an enumerated ground, is not discriminatory within the meaning of s. 15.

(c) *Section 2(a) of the Charter*

[153] A.C. argues that the legislative authorization of treatment over her sincere religious objections constitutes an unjustifiable infringement of her right to religious freedom. It is not in dispute that A.C. possessed a sincere religious belief as a Jehovah's Witness against receiving blood products and transfusions: *Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551, at para. 46.

[154] The impugned provisions of the *CFSA* operates to deprive A.C. of full decision-making authority as to whether or not she will receive blood products where medically necessary. This is clearly more than a trivial interference with her "right to manifest beliefs and practices": *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at p. 337. Where a minor is transfused against her will, she may often experience psychic harm, as described in this case. In my view, the respondent rightly concedes that s. 25 of the *CFSA* violates s. 2(*a*).

[155] In this case, the s. 7 and s. 2(*a*) claims merge, upon close analysis. 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 individual child's motivation for refusing treatment. The fact that A.C.'s aversion to receiving a blood transfusion springs from religious conviction does not change the essential nature of the claim as one for absolute personal autonomy in medical decision-making.

[156] If s. 25(8) is viewed through the lens of s. 2(*a*), the limit on religious practice imposed by the legislation emerges as justified under s. 1, for many of the same reasons that the law is not arbitrary for the purposes of s. 7. The objective of ensuring the health and safety of vulnerable young people is pressing and substantial, and the means chosen — giving discretion to the court to order treatment after a consideration of all relevant circumstances — is a proportionate limit on the right, thus satisfying the requirements under *R. v. Oakes*, [1986] 1 S.C.R. 103.

4. The Judge's Decision

[157] While factor-guided, the judge's task of assessing the best interests of the child and his or her ultimate decision to order treatment remain discretionary. Section 25(8) provides that "upon completion of a hearing, the court may authorize ... medical ... treatment that the court considers to be in the best interests of the child." This statutory discretion "must be exercised within the boundaries set by the principles of the *Charter*"; *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835, at p. 875. If the judge fails to do so, it is open to the applicant to challenge the judge's decision. Even if the legislation is constitutional, a judge's decision under it may be set aside if it is contrary to the provisions of the Act or the *Charter*.

[158] The applications judge in this case, Kaufman J., ordered treatment of A.C., then under 16. The treatment was, on the evidence, necessary to save her life. Kaufman J.

assumed for the purposes of the decision that A.C. had "capacity" to make the decision. Considering the relevant factors set out in s. 2(1), including her wish not to have the treatment, he concluded that treatment was in the child's best interests and ordered that it take place.

[159] This decision conformed to the provisions of the Act. The only possible criticism from this perspective is that the judge proceeded with the analysis on the basis of presumed "capacity". In the exigent circumstances, he did not consult with A.C. herself, nor did he review the psychiatrists' reports or any other evidence regarding capacity. As discussed above, capacity in the narrow intellectual sense of s. 25(9) of the *CFSA* does not capture the constitutionally valid thrust of the provisions pertaining to children under 16. The decision to assume capacity in the narrow sense but conclude that treatment should be ordered on the basis of other factors was therefore not in error. If time and circumstances permit, it is optimal for a judge to fully consider and give reasoned judgment on all the factors he or she takes into account. However, proceeding on the assumption of "capacity" — an assumption that favoured A.C.'s autonomy interest — was reasonable in these circumstances, where a child's life hung in the balance and the need for a decision was urgent. I would not fault the applications judge on this count.

[160] The remaining question is whether the decision conformed to the *Charter*. It is argued that once the judge presumed capacity, he was bound under the *Charter* to give effect to A.C.'s wishes. The order for treatment, it is argued, therefore violates s. 7. The flaw in this contention is the assumption that autonomy under s. 7 is absolute and trumps all other

values. As discussed above, this Court has rejected this contention.

5. Conclusion

[161] I would dismiss the appeal and affirm the constitutionality of ss. 25(8) and 25(9) of the *CFSA*. Like Abella J., I would order costs to A.C. throughout.

The following are the reasons delivered by

BINNIE J. —

[162] This is a disturbing case. The *Canadian Charter of Rights and Freedoms* enshrines in our highest law the liberty and independence of a mature individual to make life's most important choices free of government intervention, provided there is no countervailing social interest of overriding importance. This proposition is tested on this appeal by A.C., a Jehovah's Witness, who is a mature minor. She claims the right to make a choice that most of us would think is a serious mistake, namely to refuse a potentially lifesaving blood transfusion. Her objection, of course, is based on her religious beliefs.

[163] The *Charter* is not just about the freedom to make what most members of society would regard as the wise and correct choice. If that were the case, the *Charter* would be superfluous. The *Charter*, A.C. argues, gives her the freedom — in this case religious freedom — to refuse forced medical treatment, even where her life or death hangs in the

balance.

[164] Counsel for A.C. acknowledges that the state would be entirely justified in taking the decision away from A.C. if there was any doubt about her capacity, as in a situation of urgency, or whether she was acting under the influence of her parents (who are Jehovah's Witnesses). However, these matters were looked into by three psychiatrists at the Winnipeg hospital where the blood transfusion was to be administered, and the psychiatrists concluded, and the applications judge accepted, that A.C. — though under 16 years of age — was nevertheless at the material time an individual "with capacity to give or refuse consent to her own medical care" (A.R., at p. 91). The formal order of the applications judge dated April 16, 2006 so states.

[165] Counsel for A.C. argues that whether judges, doctors and hospital authorities agree with A.C.'s objection or not, the decision belongs to the patient. The essential question is not *what* is to be decided about medical treatment but *who* is to make the decision.

[166] My colleague Abella J. acknowledges that judges should be required to take the views of a mature minor into consideration when *the judge* decides what is in the best interest of A.C. But this position ignores the heart of A.C.'s argument, which is that the individual autonomy vouchsafed by the *Charter* gives *her* the liberty to refuse the forced pumping of someone else's blood into her veins regardless of what the judge thinks is in her best interest. In my respectful view, the *Child and Family Services Act*, C.C.S.M c. C80 ("*CFSA*"), is insufficiently respectful of constitutional limits on the imposition of forced medical treatment

on a mature minor. I would therefore allow the appeal.

I. Overview

[167] Forced medical procedures must be 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. A.C. had three months earlier signed an advance medical directive dated January 10, 2006 pursuant to the *Health Care Directives Act*, C.C.S.M. c. H27 ("*HCDA*"), containing her written instructions not to be given blood under any circumstances:

> I am one of Jehovah's Witnesses, and I make this directive out of obedience to commands in the Bible, such as: "Keep abstaining . . . from blood." (Acts 15:28, 29) [A.R., at p. 222]

As will be seen, the Manitoba *HCDA*, unlike the *CFSA*, permits a minor *under* the age of 16 to rebut the presumption of incapacity.

[168] The Manitoba legislature's denial of rights to young persons under the age of 16 is not in accordance with the views of its own Law Reform Commission, which concluded, in a report prepared in consultation with the province's physicians, that a "fixed age" limit is neither "practical or workable":

> We found that the mature minor rule is a well-known, well-accepted and workable principle which seems to raise few difficulties on a day-to-day basis. There was quite strong opposition to the use of a fixed age limit; the development of children was seen to be too variable to permit a fixed age to be a practical or

> workable concept. The interviews revealed no reason for concern in respect of the operation of the mature minor rule. [Emphasis added.]
>
> (*Minor's Consent to Health Care* (1995), Report No. 91, at p. 33)

[169] At the relevant time, A.C. was being treated (with her consent) with non-blood products and medication to stop the internal bleeding. She had no desire to die, but she wished to live in accordance with her religious beliefs.

[170] On April 16, 2006, A.C. experienced renewed internal bleeding. The hospital, faced with the refusal of A.C. to consent to a blood transfusion, sought the intervention of the Manitoba Director of Child and Family Services (the "Director") who immediately had A.C. apprehended as a child in need of protection (A.R., at p. 187) and sought the treatment order now under appeal.

[171] Section 25(8) of the *CFSA* provides that "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" (defined as a person under 18 years of age).

[172] Had A.C. been 14 months older on the date of the s. 25 application, she would have benefited from s. 25(9) of the *CFSA* which says that no treatment order can be made *without the consent of a young person 16 or over* unless the court is satisfied that he or she does *not* understand the information relevant to consenting or not consenting to treatment, or is *not* able to "appreciate the reasonably foreseeable consequences of making a decision to

consent or not consent".

[173] My colleague Abella J. notes, correctly, that "the psychiatric report was never subjected to a [judicial] review of any kind, let alone a searching one" (para. 119), but this is precisely the problem with the *Charter*-breaching procedure adopted by the applications judge, who refused to allow A.C. to lead evidence at the s. 25(8) hearing (which he held by conference call) of her capacity. In the learned judge's view, the *CFSA* made such evidence irrelevant in the case of a young person under 16. Her capacity, in his interpretation of s. 25, was not a "live issue". He simply accepted that A.C. "is a person with capacity to give or refuse consent to her own medical care" (see formal order April 16, 2006, A.R., at p. 91), but concluded that from *his* point of view, regardless of her capacity, it was in her best interests to receive the blood transfusion and he therefore granted the treatment order. In my view, A.C. is entitled to have her appeal disposed of on the basis that, as the formal order states, she "is a person with capacity to give or refuse consent to her own medical care".

[174] The order of the applications judge was upheld by a unanimous Court of Appeal on February 5, 2007. The issue by that time was moot, as the April 16, 2006 order had been executed, but the court heard the appeal on the basis (correctly in my view) that the *CFSA* issue was not only likely to recur but in the nature of things will generally be evasive of review. Few treatment decisions of this nature can await the outcome of the appellate process.

[175] As is described in the reasons of my colleague Abella J., the class of persons

known as “mature minors” is well established at common law. It consists of individuals who are treated as adults for the purposes of making medical treatment decisions free of parental or judicial control. At common law, proof of capacity entitles the “mature minor” to personal autonomy in making such decisions. No doubt at common law, as under a statutory authority, it is very difficult to persuade a judge that a young person who refuses potentially lifesaving medical treatment is a person of full capacity. Yet, for the reasons that follow, I believe the *Charter* required such an opportunity to be given in the case of an adolescent of the age and maturity of A.C. The fact that in the end a judge disagrees with the mature minor’s decision is not itself a lawful reason to override it.

[176] Children may generally (and correctly) be assumed to lack the requisite degree of capacity and maturity to make potentially life-defining decisions. It is this *lack* of capacity and maturity that provides the state with a legitimate interest in taking the decision-making power away from the young person and vesting it in a judge under the *CFSA*. Yet, this is not a case about broad government programs where line drawing and generalized age categories are sometimes essential and inevitable for administrative reasons. The *CFSA requires* individualized treatment decisions, and courts routinely handle capacity as a live issue under the *CFSA* in the case of minors between the ages of 16 and 18. The question here is whether in the course of those individualized *CFSA* treatment assessments the presumption of incapacity to refuse medical treatment can constitutionally be made *irrebuttable* in the case of young people under 16. I do not think it can. In such cases, the legitimate object and basis of state intervention in the life of the young person has, by reason of the judge’s finding of maturity, ceased to exist.

[177] In short, s. 25 of the *CFSA* is 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, just as is now the case with a "mature minor" who is 16 or 17 years old.

[178] The Director argues that no *Charter* rights are absolute, which is true, but the onus is on the state to justify overriding an individual's fundamental choices about invasive medical treatment. We are not dealing with categories of people classified by age for administrative convenience as, for example, say, in the case of voting rights. The *CFSA* *mandates* an individualized assessment on a patient-by-patient basis.

[179] In my opinion the deprivation of liberty or security of the person does not accord with the principles of fundamental justice where the only justification advanced for the deprivation, namely the incapacity of the young person, has been accepted by the applications judge not to exist.

II. Facts

[180] A.C. was born on June 7, 1991. At the time of the s. 25 hearing, she was 14 years and 10 months old. She had been admitted to hospital on April 12, 2006, after suffering an episode of lower gastrointestinal bleeding. The loss of blood had decreased her

haemoglobin count, but thereafter her condition stabilized for several days.

A. *The Psychiatric Assessment Report*

[181] The day following A.C.'s admission to hospital, her physician, Dr. Lipnowski, requested an assessment by the hospital's consultant psychiatrists:

> Please see 14 [year old female] admitted as [C]rohn's disease [with] lower GI bleeding. [Patient] is Jehovah's Witness refusing all blood product transfusions. Please do assess the patient to determine capability to understanding death. Thank you. [A.R., at p. 227]

The potential of death was therefore central to the inquiry. Three hospital psychiatrists, Drs. Kuzenko, Bristow and Altman, examined A.C. and reported as follows:

> [Patient] is aware of medical concern for blood loss, [decreased hemoglobin] and that if blood loss is severe, a transfusion is the recommended [treatment]. She is aware of alternatives to transfusion — [erythropoietin] and iron. States that even if she will die, she will refuse blood based on scripture "to maintain a clean standing with God." She was voluntarily baptized 2 years ago and believes that "this is the absolute truth."
>
> Sleep is "pretty good." Concentration "good." Energy "really good." Eating well (apart from this past week). [Emphasis added; A.R., at p. 227.]

[182] The psychiatrists made enquiries to determine the extent of parental influence and reported:

> [A.C.] [d]enies feeling pressured by parents and has a good relationship with

> them. Has good support system.
>
> . . .
>
> [The parents] believe she treasures her relationship with God and does not want to jeopardize it, that she understands her disease and what is happening. [A.R., at p. 228]

The psychiatric assessment report concluded:

> The patient appears to understand the nature of her Crohn's illness (and GI bleeding) and reason for admission. She also appears to understand the nature of her treatments, and that should her current medical status weaken, the treating MD's may suggest a blood transfusion. The patient understands the reason why a transfusion may be recommended, and the consequences of refusing to have a transfusion. At the time of our assessment, patient demonstrated a normal [mental status examination with] intact cognition (30/30 [Mini-Mental State Examination]). [Emphasis added; A.R., at p. 229.]

[183] In the early hours of Sunday April 16, A.C. suffered another internal bleed. Her doctor believed this new episode created an imminent and serious risk to her health and perhaps her life. He wanted to give her a blood transfusion. She refused to consent to the receipt of any blood or blood products on religious grounds.

III. Judicial History

A. *Court of Queen's Bench of Manitoba* (Kaufman J.)

[184] At the s. 25 hearing, which proceeded in the absence of A.C., her attending physician, Dr. Lipnowksi, testified that because of reduced haemoglobin levels, A.C.'s vital

organs were not receiving sufficient oxygen. Until her low haemoglobin level improved, the medical staff could not investigate by colonoscopy or other procedure whether A.C.'s intestinal bleeding was continuing. While the non-blood medication presently being administered might assist in stopping further bleeding, it would not remedy the low haemoglobin count. The risk to A.C. was significant even if the internal bleeding had stopped, because if the doctors waited for A.C.'s haemoglobin to rebuild naturally (i.e. without a blood transfusion), there could be permanent and serious damage to A.C.'s bone marrow and kidneys.

[185] The *CFSA* hearing proceeded expeditiously. Counsel representing A.C.'s family, Mr. Allan Ludkiewicz, heard the evidence on behalf of the Director and Dr. Lipnowski over a cell phone on his way to the hospital. He urged the applications judge to come to the hospital as well to review the hospital's recently completed psychiatric assessment report, but the applications judge viewed such evidence as irrelevant in light of the language of s. 25 of the *CFSA*:

> MR. LUDKIEWICZ [by telephone]: Yeah. I was going to request of the court that the, that the hearing be held at the hospital with - - if, if My Lord would, would come down. I, I believe that the - -
>
> THE COURT [by telephone]: What's the, what's the purpose of that?
>
> MR. LUDKIEWICZ: It's - - what I understand is that this patient has been assessed as being capable of making her own decisions.
>
> THE COURT: She's under 16.
>
> MR. LUDKIEWICZ: She, she's been assessed by, by the doctors. There, there is an assessment report which I would want to put into evidence first and the assessment report indicates that [A.C.] understands the nature, excuse me, of

her illness and the possible consequences.

THE COURT: Counsel, I - - where - - just help me out here. She's under 16. Is her consent required?

MR. LUDKIEWICZ: Her - - if, if she's capable, My Lord.

THE COURT: Where does it say - -

MR. LUDKIEWICZ: She's, she's in the same position as, as an adult. She makes her own medical decisions.

MR. THOMSON [Counsel for the Director]: Your Lordship, what the agency is relying on are the provisions of Section 25 of the Child and Family Services Act which clearly contemplate that that type of investigation doesn't occur under the legislation for a child who is less than 16 years of age and the provision that I would rely on in particular is subsection 9 of Section 25 of the Act.

MR. LUDKIEWICZ: Well, My, My Lord, first of all, the - - this, this is a Charter matter, to begin with. I'd like to put that on the record. It involves Section 2(a) freedom of religion. It involves Section 7, liberty and security of the person. A capable person of any age makes their own decisions when it comes to, to health care. They have they [sic] freedom of choice. So I believe that the first thing that My Lord should have before you is the assessment report. [Emphasis added; A.R., at pp. 178-79.]

[186] The s. 25 hearing proceeded as soon as counsel representing A.C.'s family arrived at the hospital. The applications judge was conferenced in by telephone. Counsel again sought to introduce evidence as to A.C.'s capacity through the psychiatric report and through A.C.'s father, but was stopped by the applications judge (A.R., at p. 201).

MR. LUDKIEWICZ: In my examination of the father. When, when I was coming to this hearing, when I was driving it was indicated that we're assuming that [A.C.] has capacity; is that correct - -

THE COURT: That's - -

MR. LUDKIEWICZ: - - or am I allowed to lead that?

> THE COURT: I'm, I'm proceeding on the assumption that she has capacity and doesn't want this done. I'm taking that as a given. [Emphasis added; A.R., at p. 199.]

When counsel for the Director sought to ask A.C.'s doctor about A.C.'s capacity the applications judge, consistently with his earlier ruling, did not allow it:

> THE COURT: I think, I think that if [A.C.'s capacity] becomes a live issue then I would want to attend and speak to the child myself and see the assessment report. But I am going to proceed, as I say. If we're going to proceed in this format then it seems to me only fair to proceed on the assumption that the child has capacity and that the child objects.
>
> If, if, if I thought that, that [A.C.'s capacity] was going to be an issue, then I would deal with it by way of attending and speaking to the child and reading the assessment report rather than hearing Dr. Lipnowski's summary or opinion based on that, counsel. So I'm going to proceed without that. [Emphasis added; A.R., at p. 201.]

[187] Based on the attending doctor's evidence, the applications judge was satisfied that there was "immediate danger as the minutes go by, if not death, then certainly serious damage". He granted the treatment order because, in his opinion, s. 25(8) of the *CFSA* requires the court to act in what the court regards as the "best interests of the child" even for minors with capacity if they are under 16 years of age. In his view, the blood transfusion would be in A.C.'s best interests. He did not address the *Charter* issues. He issued an order

> 4. That qualified medical personnel are hereby authorized to administer blood transfusions and/or blood products to the Respondent [A.C.] as they deem medically necessary without the consent of Respondent [A.C.] or her parents.

[188] Pursuant to s. 27(1) of the *CFSA*, the Director then filed a petition and notice of an application for an order declaring A.C. to be a child in need of protection. On May 1, 2006, while still apprehended, A.C. filed an application for relief under the *Charter* claiming that her apprehension and the Director's related actions violated her *Charter* rights. Subsequently the Director withdrew the apprehension and his guardianship petition. The psychiatric assessment report was filed as an exhibit on the appeal.

B. *Court of Appeal of Manitoba*, 2007 MBCA 9, 212 Man. R. (2d) 163 (Huband, Steel and Hamilton JJ.A.)

[189] Steel J.A., for a unanimous court, agreed that s. 25 of the *CFSA* violates religious freedom but found the violation was saved under s. 1 of the *Charter*. Medical treatment against an individual's wishes also violated the s. 7 interests of liberty and security of the person, but did so here in accordance with the principles of fundamental justice, and so did not result in a breach of s. 7. The age-based distinction also did not violate s. 15, since "[a]ge-based distinctions are a common and necessary way of ordering society" (para 4).

IV. Relevant Statutory Provisions

[190] *Child and Family Services Act*, C.C.S.M. c. C80

> **25(1)** Where a child has been apprehended, an agency
>
> . . .
>
> (c) may authorize the provision of medical or dental treatment for the child

if

(i) the treatment is recommended by a duly qualified medical practitioner or dentist,

(ii) the consent of a parent or guardian of the child would otherwise be required, and

(iii) no parent or guardian of the child is available to consent to the treatment.

25(2) Notwithstanding clause (1)(b) or (c), if the child is 16 years of age or older, an agency shall not authorize a medical examination under clause (1)(b) or medical or dental treatment under clause (1)(c) without the consent of the child.

25(3) An agency may apply to court for an order

(a) authorizing a medical examination of an apprehended child where the child is 16 years of age or older and refuses to consent to the examination; or

(b) authorizing medical or dental treatment for an apprehended child where

(i) the parents or guardians of the child refuse to consent to the treatment, or

(ii) the child is 16 years of age or older and refuses to consent to the treatment.

25(4) The agency shall notify the parents or guardians of the child and the child, if the child is 16 years of age or older, of the time and place at which an application under subsection (3) is to be heard, and shall do so not less than two days before the time fixed for the hearing.

. . .

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.

29(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.

V. Analysis

[191] Individuals who do not subscribe to the beliefs of Jehovah's Witnesses find it difficult to understand their objection to the potentially lifesaving effects of a blood transfusion. It is entirely understandable that judges, as in this case, would instinctively give priority to the sanctity of life. Religious convictions may change. Death is irreversible. Even where death is avoided, damage to internal organs caused by loss of blood may have serious and long lasting effects.

[192] Yet strong as is society's belief in the sanctity of life, it is equally fundamental that every competent individual is entitled to autonomy to choose or not to choose medical treatment except as that autonomy may be limited or prescribed within the framework of the Constitution. The rights under s. 2(*a*) of the *Charter* (religious freedom) and s. 7 (liberty and security of the person) are given to *everyone*, including individuals under 16 years old.

[193] Under s. 25 of Manitoba's *CFSA*, a court may authorize medical treatment of a child under 16 who is declared to be in need of protection if it considers the treatment to be "in the best interests of the child", having regard to "all relevant matters" including a series of factors enumerated at s. 2(1) of the Act, "the child's cultural, linguistic, racial and religious

heritage". Section 2(1)(f) talks about "the views and preferences of the child where they can reasonably be ascertained". Yet all of these factors are treated merely as inputs into the assessment by a third party — the judge — of a child's "best interests".

[194] In *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722, faced with an individual suffering from a mental illness, this Court recognized that a "best interests" assessment by a court is only appropriate in the absence of an individual's capacity to decide for himself or herself. The province in that case sought to protect individuals who are vulnerable because of mental illness in much the same way as the province in this case seeks to protect those who are vulnerable because of youth. It was made clear in that case that the assessment of an individual's capacity and his or her ability to appreciate the choice that must be taken is completely distinct from an assessment of what is in that same individual's best interests from an objective point of view. McLachlin C.J. (in dissent, but not on this issue) described the balance that must be struck between the value of autonomy and the need to protect the vulnerable:

> Like understanding, appreciation does not require agreement with a particular conclusion, professional or otherwise. A patient may look at the pros and cons of treatment and arrive at a different conclusion than the medical experts. Nor does it amount to a "best interests" standard. A patient who is capable has the right to *refuse* treatment, even if that treatment is, from a medical perspective, in his or her best interest. It is crucial to guard against interpreting disagreement with a particular diagnosis or proposed treatment plan as itself evidence of incapacity. [Underlining and italics added; para. 19.]

In this case, the majority's interpretation of the *CFSA* does not render rebuttable the presumption that persons under 16 lack the capacity to refuse medical treatment. Under their

interpretation of the *CFSA*, even if a minor under 16 demonstrates his or her capacity, he or she is still not treated in the same manner as a minor who is 16 and over. His or her demonstrated capacity remains 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. A.C.'s position throughout this case has been that once it is established that she is an individual with "capacity" the applications judge ought to cede to her the power to decide to have or not to have the blood transfusion. In seeking to set aside the April 16, 2006 order, A.C. asks for either a constitutional exemption or the nullification of ss. 25(8) and 25(9) of the *CFSA*, (A.F., at paras. 114 and 116). The sliding scale of weight the majority is prepared to give to her views is not responsive to her argument. Her point is: who decides?

[195] In *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315, this Court upheld an Ontario child welfare statute that allowed a court to order that a blood transfusion be given to a baby against the parent's religious convictions because "a parent's freedom of religion does not include the imposition upon the child of religious practices which threaten the safety, health or life of the child" (para. 225). The present situation is clearly distinguishable because here A.C.'s *own* physical integrity and religious conviction are in issue, and there was no evidence, and no argument, that A.C. was somehow acting under parental influence.

A. *The Charter Right to Personal Autonomy*

[196] A competent and informed adult may always refuse treatment. This is a right that long predated the *Charter*. Health care providers must obtain a legally valid consent before treating patients: *Hopp v. Lepp*, [1980] 2 S.C.R. 192; *Reibl v. Hughes*, [1980] 2 S.C.R. 880; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.). In *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119, this Court endorsed the proposition that "[t]he fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination" (p. 135).

[197] This right to personal autonomy is, of course, independent of any religious conviction, although religion may on occasion be a motivating factor.

[198] There is a strong consensus among common law countries regarding the right to refuse medical treatment, even if this leads to death. (See A. Meisel, "The Legal Consensus About Forgoing Life-Sustaining Treatment: Its Status and Its Prospects" (1992), 2 *Kennedy Inst. of Ethics* J. 309; B. M. Dickens, "Medically Assisted Death: Nancy B. v. Hôtel-Dieu de Québec" (1993), 38 *McGill L.J.* 1053, at p. 1060; *Airedale NHS Trust v. Bland*, [1993] 1 All E.R. 821 (H.L.), at p. 891; *Re C (adult: refusal of medical treatment)*, [1994] 1 All E.R. 819 (Fam. Div.); *Re T (adult: refusal of medical treatment)*, [1992] 4 All E.R. 649 (C.A.); *Re B (adult: refusal of medical treatment)*, [2002] EWHC 429 (Fam.), [2002] 2 All E.R. 449; *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990); and *Auckland Area Health Board v. Attorney-General*, [1993] 1 N.Z.L.R. 235 (H.C.).)

[199] In Canada, this was recognized by the Ontario Court of Appeal in the *Malette*

case. Mrs. Malette was a Jehovah's Witness who arrived at the hospital unconscious but who carried with her a signed medical alert card specifying that no blood be administered under any circumstances. Nevertheless, the doctor (no doubt acting on a belief in the sanctity of life) gave Mrs. Malette a blood transfusion. He was held liable for battery. The court stated:

> A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment. . . . The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others.
>
> . . .
>
> The state's interest in preserving the life or health of a competent patient must generally give way to the patient's stronger interest in directing the course of her own life. . . . Recognition of the right to reject medical treatment cannot, in my opinion, be said to depreciate the interest of the state in life or in the sanctity of life. Individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life. [Emphasis added; pp. 424 and 429-30.]

Malette was endorsed by the majority opinion in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at p. 598.

[200] In *Nancy B. v. Hôtel-Dieu de Québec* (1992), 69 C.C.C. (3d) 450, the Superior Court of Quebec applied the *Civil Code of Lower Canada* to hold that Mrs. B. had the right to discontinue her respiratory support treatment, even though this would soon lead to her

death. The majority opinion in *Rodriguez*, at p. 598, confirmed that *Nancy B.* correctly states the law in common law provinces as well.

[201] Professor Bernard Dickens concludes, I think correctly, that in these cases the courts "have accepted the legal option of mentally competent free individuals to risk preventable death rather than be compelled to live under conditions they find objectionable" (p. 1065 (emphasis added)).

B. *The Personal Autonomy of "Mature Minors"*

[202] These principles were applied in the context of "mature minors" by the British Columbia Court of Appeal in *Van Mol (Guardian ad Litem of) v. Ashmore*, 1999 BCCA 6, 168 D.L.R. (4th) 637, at para. 75:

> But once the required capacity to consent has been achieved by the young person reaching sufficient maturity, intelligence and capability of understanding, the discussions about the nature of the treatment, its gravity, the material risks and any special or unusual risks, and the decision about undergoing treatment, and about the form of the treatment, must all take place with *and be made by* the young person whose bodily integrity is to be invaded and whose life and health will be affected by the outcome. [Underlining and italics added.]

A.C. is not an adult, but nor was she a toddler at the relevant time. The court in *Van Mol* quite rightly viewed the young person with capacity as entitled to *make* the treatment decision, not just to have "input" into a judge's consideration of what the judge believes to be the young person's best interests. Under Abella J.'s approach, the court may (or may not)

decide to give effect to the young person's view, but it is still the court that makes the final decision as to what is best for the young person. *This* mature young person, however, insists on the right to make her own determination about what treatment to receive or not to receive, based on a mature grasp of her perilous situation.

C. *What is "Capacity"?*

[203] The respondent Director points out, correctly in my view, that "capacity is about more than intelligence". He goes on to describe "capacity" as

> "ethical, emotional maturity"; in short, wisdom and a sense of judgment. Moreover, capacity, however defined, is by no means the only factor governing one's ability to make an informed healthcare decision. As important is whether the choice is made *voluntarily* and whether it is, in fact, an *informed* decision. [Emphasis in original; R.F., at para. 35.]

The Chief Justice objects that the Director's "broader definition of maturity [cannot be equated] with the more limited definition of capacity in s. 25(9) of the *CFSA*" (para. 147), but of course the Director was specifically talking about *capacity* in the context of s. 25(9), which is what the argument in this case is all about. In any event, the greater includes the lesser.

[204] I agree with the Director's view of what constitutes "capacity" in this context, as did the *Van Mol* court when it spoke of "capacity" as being attained when the young person has achieved "sufficient maturity, intelligence and capability of understanding" (para. 75). This approach to capacity, in my view, is reflected in s. 25(9) of the *CFSA* which relates

capacity to the ability

> (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.

[205] In this case, the formal order dated April 16, 2006 flatly accepts A.C.'s capacity as a fact, and the hospital's psychiatric unit reported that A.C.'s decision was both informed and voluntary. No one contends otherwise.

D. *The Constitutional Objection*

[206] The Crown supports the validity of the *CFSA* on the basis that decisions about medical treatment cannot be left in the hands of young persons because they cannot be expected to fully grasp the nature or seriousness of their medical condition or the consequences of refusing consent to treatment. The court is therefore authorized to grant or withhold consent based on the "best interests of the child".

[207] Of course, if a teenager (as in this case) *does* understand the nature and seriousness of her medical condition and is mature enough to appreciate the consequences of refusing consent to treatment, then the justification for taking away the autonomy of *that* young person in such important matters does not exist.

[208] As mentioned, the reasons of my colleague Abella J. attempt to soften the *CFSA* scheme by interpreting the scope of "the best interests of the child" test to include the judicial notion of "mature minor" and consideration of A.C.'s capacity, but the brunt of A.C.'s objection is directed at a prior question, whether the state can impose a "best interests of the child" test when the judge accepts that the factual basis for its imposition does not exist.

E. *The Irrebuttable Presumption of Incapacity*

[209] Having accepted that A.C. was a "person with capacity to give or refuse consent to her own medical care" (A.R., at p. 91), the applications judge nevertheless concluded that s. 25(8) of the *CFSA* made that inquiry irrelevant in the case of a young person under 16 years of age because, as the Director puts it in his factum,

> there is no "mature minor" exception in the *CFSA*. There is nothing ambiguous about the delineation between a child over the age of 16 and a child under the age of 16 in s. 25 of the *CFSA*. The former is deemed capable of making treatment decisions (rebuttable on evidence to the contrary), while the treatment decisions of [a person under 16] even if she is capable, will not be dispositive. [Emphasis in original; R.F., at para. 46.]

Similarly, in the Court of Appeal the parties agreed that the court "would proceed in the same manner as did [the applications judge]; that is, by assuming that A.C. had capacity" and on that basis, determine the "pure question of law with respect to statutory interpretation [ss. 25(8) and 25(9) of the *CFSA*] and the impact of that interpretation on A.C.'s *Charter* rights" (C.A. rehearing motion, 2007 MBCA 59, 214 Man. R. (2d) 177, at para. 14).

[210] Steel J.A. for the Court of Appeal concluded, and I agree with her succinct interpretation:

> Reading s. 25(8) together with s. 25(9), in the context of the whole *CFSA*, it seems clear that the legislature did direct its mind to the question of a mature minor. The language is plain. It decided to provide for a modified mature minor rule where the treatment decisions of those 16 and over with capacity would be respected. For those under 16, *with or without capacity*, the court would decide based on the best interests tests. That does not mean that the child's wishes and capacity are not considered when ascertaining what is in the child's best interests, but they are not determinative factors. [Underlining and italics added; para. 50.]

The question is whether the "modified mature minor" rule can pass *Charter* muster.

F. *Charter Objections to the Irrebuttable Presumption of Incapacity of Young Persons Under 16 Years Old*

[211] The appellant A.C. contends that the irrebuttable presumption of incapacity to consent to or refuse medical treatment violates her freedom of religion (s. 2(*a*)), her right not to be deprived of her liberty or security of the person except in accordance with the principles of fundamental justice (s. 7), and her right to be free of age discrimination (s. 15).

(1) Freedom of Religion

[212] Section 2(*a*) of the *Charter* provides that "[e]veryone has the following fundamental freedoms [including] freedom of conscience and religion". "Everyone" includes A.C.

[213] Jehovah's Witnesses believe that blood represents life and that respect for this gift from God requires the faithful to abstain from accepting blood to sustain life. They say that the Bible's prohibition applies equally to eating, drinking and transfusing blood and is not lessened in times of emergency. They believe that observance of this principle is an element of their personal responsibility before God. In *Malette*, the Ontario Court of Appeal recognized that "[i]f [Mrs. Malette's] refusal involves a risk of death, then, according to her belief, her death would be necessary to ensure her spiritual life" (p. 429).

[214] The protection afforded to freedom of conscience and religion by s. 2(*a*) of the *Charter* covers religious practices as well as religious beliefs:

> Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.
>
> (*R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at p. 337)

There is no doubt that A.C.'s belief was sincere, as must be established by a s. 2(*a*) claimant (*Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551, at para. 46; *Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256, at paras. 34-35). It is not contested that the rejection of blood transfusions by Jehovah's Witnesses is fundamental to their religious convictions. Nor would A.C.'s rejection of a blood transfusion harm anyone except (potentially) herself.

[215] Section 25(8) of the *CFSA* authorizes an applications judge to substitute his view of what is in "the best interests of the child" for the young person's religious conviction that required her to refuse the blood transfusion. The interference with A.C.'s religious conscience far exceeded the "non-trivial" threshold established in *Amselem*, and it was rightly conceded by the respondent that s. 25 of the *CFSA* violated s. 2(*a*), subject, of course, to the s. 1 defence advanced by the government.

(2) Liberty and Security of the Person

[216] Section 7 of the *Charter* provides:

> **7.** Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

"Everyone" includes A.C.

(3) The Liberty Interest

[217] The judgment under appeal concluded that A.C. was not at liberty to refuse a blood transfusion. The s. 7 liberty interest is not limited to freedom from physical restraint, but it can certainly be appreciated that forced medical treatment is a direct physical intrusion

into the body of the patient. Moreover it is not without risks[3]. In any event, the s. 7 liberty interest is engaged when the state steps in to prohibit (or compel) fundamental life choices that "[e]veryone" is otherwise free to pursue (or to decline to pursue). In *B. (R.) v. Children's Aid*, La Forest J. observed, with respect to the liberty interest in s. 7, that

> [i]n a free and democratic society, the individual must be left room for personal autonomy to live his or her own life and to make decisions that are of fundamental personal importance. [para. 80]

To a Jehovah's Witness, nothing is of more "fundamental personal importance" than observance of the teachings of the church.

[218] Wilson J. in *R. v. Morgentaler*, [1988] 1 S.C.R. 30, had earlier grounded the liberty interest in the fundamental concepts of human dignity, personal autonomy, privacy and choice in decisions going to the individual's fundamental being (p. 166). In *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844, La Forest J. observed that he did "not by any means regard this sphere of autonomy as being so wide as to encompass any and all decisions that individuals might make in conducting their affairs. Indeed, such a view would run contrary to the basic idea . . . that individuals cannot, in any organized society, be guaranteed an

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[3]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.

unbridled freedom to do whatever they please" (para. 66). However, he went on to say, such liberty interests do extend to matters that "can properly be characterized as fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence" (para. 66). This approach to the liberty interest has since been adopted and applied in other cases including *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571, at para. 85; *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307, at para. 54; *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791; *B. (R.) v. Children's Aid*.

[219] The Court has thus long preached the values of individual autonomy. In this case, we are called on to live up to the s. 7 promise in circumstances where we instinctively recoil from the choice made by A.C. because of our belief (religious or otherwise) in the sanctity of life. But it is obvious that anyone who refuses a potentially lifesaving blood transfusion on religious grounds does so out of a deeply personal and fundamental belief about how they wish to live, or cease to live, in obedience to what they interpret to be God's commandment. As such, A.C.'s s. 7 liberty interest is directly engaged.

(4) Security of the Person

[220] The s. 7 reference to "security of the person" affords "[e]veryone" protection from serious assault on his or her physical, psychological or emotional integrity: *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46;

Rodriguez, at pp. 587-88 (*per* Sopinka J.), and at p. 618 (*per* McLachlin J.); *Chaoulli*, at paras. 116 and 122 (*per* McLachlin C.J. and Major J.), and *Blencoe*, at para. 55. An unwanted blood transfusion violates what *Chaoulli* describes as the fundamental value of "bodily integrity free from state interference" (para. 122).

(5) Principles of Fundamental Justice

[221] The more difficult step in the s. 7 analysis generally is to identify the principle of fundamental justice that is said to be breached. In the present case, the principles of fundamental justice at issue are both procedural and substantive.

[222] In terms of substantive justice, the irrebuttable presumption takes away the personal autonomy of A.C. and other "mature minors" *for no valid state purpose*. The purpose of the *CFSA* is to defend the "best interests" of children who cannot look after themselves and who are, therefore "in need of protection". This means, in the present context, children who do not have the capacity (broadly defined) to make their own decisions about medical treatment. But the court order of April 16, 2006 accepted that A.C. *does* have that capacity. At common law, as Abella J. shows, mature minors have the *right* to make such decisions for themselves when their level of maturity warrants it. If the legislative net is cast so widely as to impose a legal disability on a class of people in respect of an assumed developmental deficiency that demonstrably does not exist in their case, it falls afoul of the "no valid purpose" principle referred to by Sopinka J. in *Rodriguez*, at p. 594:

> Where the deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems to me that a breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose.

[223] Arbitrariness is a breach of fundamental justice, and arises where a law "bears no relation to, or is inconsistent with, the objective that lies behind [it]". The *no valid state purpose* principle requires the identification of a public interest said to be advanced by the challenged law. The *no arbitrariness* principle looks at what valid state interests are said to be advanced and examines the relationship (if any) between the state purpose(s) and the impugned measure. The "no arbitrariness" principle was addressed by the Chief Justice and Major J. in *Chaoulli*, at para. 131:

> The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection.
>
> (See also *Rodriguez*, at pp. 594-95.)

Here, for the reasons already mentioned, the limit (i.e. the irrebuttable presumption) when applied to young persons of capacity has "no real relation" to the legislative goal of protecting children who *lack* such capacity. The deprivation in the case of mature minors (a class to which A.C. belongs) is arbitrary, and the deprivation therefore violates s. 7.

[224] The principles of fundamental justice also include, of course, procedural fairness whose content varies with the context of the case and the interests at stake. In *Morgentaler*,

the procedures set out by the legislature to allow women access to legal abortions were held to be deficient because they caused undue delay and were unavailable to many women. In the present case, the procedures in the *CFSA* are deficient because they do not afford a young person the opportunity to rebut the very presumption upon which the court's authority to act in the best interests of the young person rests — the presumption that she is incapable of making that decision for herself. Section 25's failure to leave room (in what is conceded to be an individualized process) for the young person to rebut this presumption violates fundamental procedural fairness. The state can have no valid interest in preventing a young person from challenging the legislative presumption that she lacks the capacity to determine what medical procedures she should undergo. The Director urges administrative concerns such as the lack of time and facilities that a s. 25 hearing may encounter, but those same concerns exist in the cases of young persons 16 and 17 years old, yet the *CFSA* contemplates contested capacity hearings in those cases.

[225] It is perfectly acceptable that the "default position" is to let the judge decide. Indeed the judge should always make the final decision — if there is any doubt, on a balance of probabilities — that the young person is capable. It is perfectly acceptable in an emergency situation where the issue of capacity cannot properly be explored for the judge to proceed to a decision about treatment as quickly as circumstances require. What is unfair, in my view, is for the presumption of incapacity to remain irrebuttable in circumstances where the young person's capacity *can* fairly be determined in a timely way, as it was in this case by the three hospital psychiatrists, whose opinion of A.C.'s capacity was accepted by the judge.

(6) Equality Rights

[226] Steel J.A. concluded:

> While the *CFSA* mandates differential treatment based on age, the appellants did not establish that it does so in an arbitrary manner or that it marginalizes or treats children as less worthy on the basis of irrelevant characteristics. The distinction between children over and under 16 is not an affront to human dignity in the manner contemplated in *Law*. [para. 106]

The "dignity" analysis has subsequently been reorganized by *R. v. Kapp*, 2008 SCC 41, [2008] 2 S.C.R. 483, where the majority explained at para. 23 that instead of "dignity" the analysis in a particular case "more usefully focusses on the factors that identify impact amounting to discrimination".

[227] The dispute here does not turn on the differential treatment of children and adults generally, but on the irrebuttable presumption in the *CFSA* that "mature minors" under 16 are to be treated differently than the comparator group, namely, mature minors who are 16 and over. The latter are deemed by the legislature to have the capacity to make decisions about their own medical treatment unless the contrary is shown. The former are denied even the opportunity to demonstrate their capacity in deciding matters that affect their vital physical and psychological interests.

[228] The Attorney General of Manitoba concedes that the *CFSA* imposes differential

treatment on the basis of age, but denies that the distinction is discriminatory (factum, at para. 37).

[229] In this respect, the Attorney General of Manitoba relies strongly on the comments of the Chief Justice in *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84, [2002] 4 S.C.R. 429:

> [U]nlike race, religion, or gender, age is not strongly associated with discrimination and arbitrary denial of privilege. This does not mean that examples of age discrimination do not exist. But age-based distinctions are a common and necessary way of ordering our society. [para. 31]

Gosselin, of course, involved a *Charter* challenge to the age-related classification of benefits under Quebec social welfare legislation. It is apparent that in the administration of such benefit programs, certain generalizations must be made about the characteristics of people included in the different classifications, otherwise the program may become unworkable. The present context is quite different. A.C. is not seeking a government benefit. She is protesting a state-authorized imposition of a blood transfusion to which she objects on religious grounds. On this point, Professor Hogg observes:

> . . . our laws are replete with provisions in which age is employed as the qualification for pursuits that require skill or judgment. Consider the laws regulating voting, drinking, driving, marrying, contracting, will-making, leaving school, being employed, etc. In regulating these matters, all jurisdictions impose disabilities on young people, employing age as a proxy for ability. Such stereotyping is inevitably inaccurate, because individuals mature at different rates. In principle, the use of age could be eliminated, because each individual could be tested for performance of each function. Age is used as a qualification for no other reason than to avoid or reduce the administrative burden of

individualized testing. [Emphasis added.]

(P. W. Hogg, *Constitutional Law of Canada* (5th ed. 2007), vol. 2, at p. 668)

As emphasized earlier, the *CFSA requires* individualized assessment.

[230] A.C. compares her position to that of mature minors who are 16 and 17 years old and who are not confronted with an irrebuttable presumption of incapacity. She underlines the significant intrusion in her life (however well-intentioned and medically appropriate) posed by forced medical treatment. Her objection would be the same whether or not the refusal of consent in a particular case is based on religious grounds. Within the class of mature minors, the line drawn at 16 does not correspond with the claimant group's reality as concluded by the Manitoba Law Reform Commission, in its rejection of a "fixed age" cut-off in the report previously mentioned, *Minor's Consent to Health Care*, at pp. 33 and 38.

[231] That having been said, I do not think the real *gravamen* of A.C.'s complaint is age discrimination. Her fundamental concern is with the forced treatment of her body in violation of her religious convictions. In the circumstances, I think that rather than pursue a full s. 15(1) analysis, it is preferable to treat the elements of her s. 15 argument as part of A.C.'s response to the government's s. 1 justification to the violations of s. 2(*a*) and s. 7 of the *Charter*.

G. *Is the CFSA Irrebuttable Presumption Justified as a Reasonable Limit in a Free and Democratic Society Under Section 1 of the Charter?*

[232] At the September 7, 2006 hearing before the Manitoba Court of Appeal, counsel for the Attorney General was asked whether she wished to adduce s. 1 evidence. Counsel replied that she "was content to rely on the record as it stood" (C.A. judgment, at para. 37). Accordingly, if there exists some evidence of a state interest in subjecting the medical treatment of minors under 16 to judicial control *irrespective* of their capacity to make these decisions for themselves, it was not put before the Court.

[233] I accept that the care and protection of children is a pressing and substantial legislative objective that is of sufficient importance to justify limiting a *Charter* right. However, the impugned procedure under s. 25 of the *CFSA* is not rationally connected to that objective. The problem is that the *CFSA* itself acknowledges in s. 25(9) that mature minors who are 16 and over are presumed to be of sufficient capacity to make their own treatment decisions, and it seems to me "arbitrary, unfair or based on irrational considerations" (as those words are used in *R. v. Oakes*, [1986] 1 S.C.R. 103, at p. 139) to deny mature minors under 16 the opportunity of *demonstrating* what in the case of the older mature minors is *presumed* in their favour.

[234] Certainly the irrebuttable presumption of incapacity does not impair "'as little as possible' the right or freedom in question" (*Oakes*, at p. 139). The Manitoba legislature itself has recognized in other statutes that young persons under 16 may have the requisite capacity to make important decisions about their health and medical treatment. In the *HCDA*, mentioned previously, s. 4(2) provides that "[i]n the absence of evidence to the contrary, it shall be presumed for the purpose of this Act (a) that a person who is 16 years of age or more

has the capacity to make health care decisions [rebuttable by the state]; and (b) that a person who is under 16 years of age does not have the capacity to make health care decisions [rebuttable by the person below age 16]". It was under the *HCDA*, of course, that A.C. gave her directive dated January 10, 2006 that she was not to receive a blood transfusion.

[235] The *Mental Health Act*, C.C.S.M. c. M110, also creates a *rebuttable* presumption of incapacity for minors under 16 (s. 2). Although each of these statutes has its own particular focus, the contrasting treatment of mature minors is striking. Its justification is neither self-evident nor supported by s. 1 evidence. It seems obvious that the rebuttable presumption enacted in relation to mature minors under the age of 16 by the *HCDA* and the *Mental Health Act* offers an available legislative solution that both protects the state interest in looking out for those who lack the capacity to look out for themselves and the need to minimally impair the rights of mature minors under 16 years of age who do *not* lack that capacity.

[236] As stated, both the Director and the Attorney General of Manitoba rely on the fact that the *CFSA* is sometimes used in emergency situations where there is neither the time nor the facilities to explore properly the capacity of the mature minor. This is undoubtedly true, and in such cases the young person under 16 may not have the time or the opportunity to rebut the "default" position of incapacity, and will have a s. 25 order made in what the judge considers to be their best interests. The point here is that s. 25 procedure is not limited to emergency situations, and reference to factors peculiar to an emergency cannot save the section as it stands.

[237] Finally, the irrebuttable presumption has a disproportionately severe effect on the rights of mature minors under 16 because they do not suffer from the lack of capacity or maturity that characterizes other minors. The state's interest in ensuring judicial control over the medical treatment of "immature" minors is not advanced by overriding the *Charter* rights of "mature" minors under 16 who are in no such need of judicial control. Nor has the respondent shown that the irrebuttable presumption in the *CFSA* produces "proportionality between the deleterious and the salutary effects" (*Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835, at p. 889 (emphasis deleted)). Indeed based on what I have already said, I believe A.C. has demonstrated that the deleterious effects are dominant.

VI. Conclusion

[238] Accordingly, I would allow the appeal and answer the constitutional questions as follows:

1. Do ss. 25(8) and 25(9) of *The Child and Family Services Act*, S.M. 1985-86, c. 8, infringe s. 2(*a*) of the *Canadian Charter of Rights and Freedoms*?

   Answer: Yes.

2. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

   Answer: No.

3. Do ss. 25(8) and 25(9) of *The Child and Family Services Act*, S.M. 1985-96, c. 8, infringe s. 7 of the *Canadian Charter of Rights and Freedoms*?

Answer: Yes.

4. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

   Answer: No.

5. Do ss. 25(8) and 25(9) of *The Child and Family Services Act*, S.M. 1985-86, c. 8, infringe s. 15 of the *Canadian Charter of Rights and Freedoms*?

   Answer: Not necessary to answer.

6. If so, is the infringement a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society under s. 1 of the *Canadian Charter of Rights and Freedoms*?

   Answer: Not necessary to answer.

[239] The appellants should have their costs in this Court and in the courts below.

APPENDIX

Child and Family Services Act, C.C.S.M. c. C80

Sections 25(8) and 25(9), the two provisions being challenged in this case:

> **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.

Section 2(1):

2(1) The best interests of the child shall be the paramount consideration of the director, an authority, the children's advocate, an agency and a court in all proceedings under this Act affecting a child, other than proceedings to determine whether a child is in need of protection, and in determining the best interests of the child all relevant matters shall be considered, including

(a) the child's opportunity to have a parent-child relationship as a wanted and needed member within a family structure;

(b) the mental, emotional, physical and educational needs of the child and the appropriate care or treatment, or both, to meet such needs;

(c) the child's mental, emotional and physical stage of development;

(d) the child's sense of continuity and need for permanency with the least possible disruption;

(e) the merits and the risks of any plan proposed by the agency that would be caring for the child compared with the merits and the risks of the child returning to or remaining within the family;

(f) the views and preferences of the child where they can reasonably be ascertained;

Appeal dismissed, BINNIE J. *dissenting.*

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