"WHY NOT TELL IT LIKE IT IS?": THE EXAMPLE OF P.H. v. EASTERN REGIONAL INTEGRATED HEALTH AUTHORITY, A MINOR IN A LIFE-THREATENING CONTEXT

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INTRODUCTION

Adolescents in life-threatening circumstances present particular challenges to existing legal principles about consent to treatment. *P.H. v. Eastern Regional Integrated Health Authority*[1](*SJL*), a case from the trial division in Newfoundland and Labrador, illustrates these problems. Social attitudes about the need to protect adolescents while recognizing their growing independence, and ambiguities about the distinction between developmental processes and pathology, form a complicated backdrop of ideas about the interpretation of statutory authority and common law principles.

In Canada, a competent adult may generally make any decision about his or her own health care, regardless of whether the choice is unpopular, against medical advice, or even likely to be fatal. Outside of emergencies and some narrowly restricted psychiatric or public health contexts, health providers must obtain consent from the individual before administering treatment.[2] Otherwise a doctor may be committing the tort of battery, even if the non-consensual treatment saves the individual's life.[3] An adult may refuse any treatment for any reason. Canadian courts have decided adults may refuse blood products because of religious convictions, and they may decline life-saving chemotherapy due to side effects.[4] Other cases involve the withdrawal of ongoing treatment, a decision that will result in death.[5] It does not matter whether the decision, to others, is principled or silly. Based on the value of

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[1] 2010 NLTD 34, 294 Nfld & PEIR 248 [*SJL*].

[2] Anomalies exist in the psychiatric context and in the public health context. In some jurisdictions, such as British Columbia, (*Mental Health Act,* RSBC 1996, c 288) involuntarily detained psychiatric patients can be treated without consent without any consideration of whether they are competent. Other jurisdictions, including Nova Scotia (*Health Promotion Act*, SNS 2004, c 4), Quebec (*Public Health Act*, RSQ, c S-2.2), and Ontario (*Health Protection and Promotion Act*, RSO 1990, c H-7), have legislation requiring a person infected by a communicable disease to undergo compulsory medical treatment.

[3] *Malette v Shulman* (1990), 67 DLR (4th) 321, 72 OR (2d) 417 (Ont CA) [*Malette*]; *Hopp v Lepp,* [1980] 2 SCR 192, 112 DLR (3d) 67.

[4] See, for example, *Malette, ibid; Alberta (Director of Child Welfare) v BH,* 2002 ABCA 216, 6 Alta LR (4th) 32 [*BH*].

[5] *Nancy B v Hotel-Dieu de Quebec* (1992), 69 CCC (3d) 450 (Qc Sup Ct).

personal autonomy, namely that people should be free to direct their own lives, decisions about what to do with one's body rest with the individual.[6]

For young persons, the law on health care decisions is more complicated. This paper looks at the matrix of legal issues and social attitudes involved in health care decisions for young persons when very serious consequences may result from refusing to accept treatment. My comments focus on *SJL*, a decision of the Newfoundland and Labrador Supreme Court Trial Division that concerns a 16-year-old who had been involved with the mental health system for several years, and had engaged in many acts of serious self-harm. In his judgment, LeBlanc J. relied on two important decisions of the Supreme Court of Canada: *Manitoba (Director of Child and Family Services) v. C.(A.)*[7] and *Starson v. Swayze*.[8]

Where adolescents are concerned, a patchwork of statutory and common law provisions which involve determinations about competence in various contexts, the concept of the "mature minor", and the 'best interests' principle make up the legal framework for young persons. Child protection legislation, laws regulating the operation of hospitals, statutes governing health decision-making, as well as codes of professional ethics for health care professionals, may all be brought into play, along with the court's *parens patriae* jurisdiction.[9]

Despite this, the courts invariably intervene in one circumstance: when the young person refuses treatment that is likely to save that individual's life.[10] That is, where the court finds that death is likely without treatment and the treatment is likely to be successful, there will be an order over the objection of the child or whichever adult has refused on the child's behalf. Despite arguments by some scholars that minors could refuse life-sustaining treatments in the right case,[11] courts consistently apply the best interests principle over a recognition of competence. In contrast to adults, where autonomy is paramount, the value of living takes precedence over autonomy when a young person is involved.

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[6] *R v Morgentaler*, [1988] 1 SCR 30, 62 CR (3d) 1.

[7] 2009 SCC 30, [2009] 2 SCR 181 [*AC*].

[8] 2003 SCC 32, [2003] 1 SCR 722 [*Starson*].

[9] *Parens patriae* jurisdiction refers to the public policy power of the state to make decisions to protect people who are unable to act on their own behalf.

[10] See for example *AC, supra* note 7; *BR v Children's Aid Society of Metropolitan Toronto,* [1995] 1 SCR 315; *H(B) (Next Friend of) v Alberta (Director of Child Welfare)*, 2002 ABQB 898; *H(T) v Children's Aid Society of Metropolitan Toronto* (1996), 138 DLR (4th) 144 (Ont Ct J (Gen Div)).

[11] See for example JM Gilmour, "Death, Dying and Decision-Making about End of Life Care" in J Downie et al, eds, *Canadian Health Law and Policy,* 4th ed (Toronto: Butterworths, 2011) 385 at 389-394. She argues that more complex decisions or more serious consequences require more advanced abilities to comprehend, assess, evaluate, and judge. But that is not to say that a mature minor can never reject life-sustaining treatment. Rather, the minor must have sufficient judgment to do so, and a conclusion that the minor is capable of making such a choice should be subject to closer scrutiny.

In my view, it is right to apply this principle to young persons in life-threatening circumstances. As a society, it is our collective responsibility to keep children safe. Where the value of autonomy threatens the very existence of a child living, it needs to give way to the principle of best interests.

However, the analysis in the cases before the courts has depended on individualized assessments and vague principles that have created a lack of clarity in situations that are agonizing for all concerned. I suggest a more straightforward approach that would do away with questions of competence in life or death situations involving minors by applying a more standard principle, one that is consistent with the results in past cases. We would acknowledge that irrespective of findings about competence and the value of autonomy, the choice is to preserve the child's life because that is in his or her best interest. Limited exceptions would exist where the proposed treatment is extremely painful, onerous, and has a poor chance of success.[12] Such an approach would alleviate, at least to some extent, the uncertainty in these emotionally-charged circumstances.

In this paper I will discuss three factors that underlie both the confusion in this area and the reluctance to close off the possibility that minors could decide to refuse life-saving medical treatment in the right circumstances. First, the question of a life-saving treatment for young persons is a very particular context that requires a unique approach. Unlike other choices that confront adolescents, where the recognition of adolescent autonomy is appropriate, the consequences of decisions here are simply too grave and possibly irreversible. Secondly, the arbitrariness of a bright line between childhood and adulthood is evident. Depending on the particular jurisdiction, the law protects an 18-year-old from decisions that are considered very dangerous and foolish, but not a 19-year-old. Also, there are difficulties with the meaning of maturity and gradations in legislation, where there is an attempt to give older teenagers more voice than younger teenagers on medical choices. Thirdly, a mental health diagnosis has a complicated impact on decisions. Mental health diagnoses in minors tend to blur two concepts: youth and capacity. As well, a mental health condition may mean that the treatment protocol is especially problematic, sometimes obscuring the distinction between detention and treatment.

In the following section I will outline the troubling facts in *SJL*. Next, I move on to describe briefly the two decisions of the Supreme Court of Canada, *AC* and *Starson,* which are important references about treatment, autonomy, competence, and best interests for the judge in *SJL*. I will then set out the decision made by

[12] For example, where a treatment is invasive or likely to be emotionally traumatic, but not likely to preserve the young person's life for any reasonable period of time, the courts have been less likely to override a refusal. See for example, *Walker (Litigation Guardian of) v Region 2 Hospital Corp* (1994), 116 DLR (4th) 477, 4 RFL (4th) 321 (NB CA) [*Walker*]; *K(LD), Re* (1985) 48 RFL (2d) 164, 23 CRR 337 (Ont Prov Ct (Fam Div)) [*K(LD)*]; *Saskatchewan (Minister of Social Services) v P(F) (K'aila)* (1990), 69 DLR (4th) 134 (Sask Prov Ct).

LeBlanc J. in *SJL*, highlighting the complexities of the treatment order in this case. I next go on to comment on three factors, well-demonstrated in *SJL*, that underpin the dilemma involved with minors and medical decision-making in dire circumstances: the significance of a life and death context; the role of chronological age; and the impact of a psychiatric diagnosis. Finally, despite the critiques associated with the best interests principle, I will conclude that the best interests approach is appropriate when the life of a minor is at stake.

Background Facts

In *SJL,* S's mother tried to prevent her daughter from leaving the hospital by asking the court to find that her daughter was not competent to make her own decisions about health care. S was just over 16 years at the time of the hearing. The facts are heartbreaking and disturbing.

Over the preceding two years, S had engaged in a wide range of extremely dangerous activities that were potentially fatal to her. These included several overdoses of acetaminophen, and swallowing objects such as batteries, a butter knife, scissors, part of a compass, the blade of a steak knife, bottle caps, a sock, and clips from a hospital bed. She had attempted to strangle herself with strings from her own clothing, banged her head against the wall, and repeatedly cut her wrists. The acts of self-harm occurred not only during periods when she was discharged from the hospital on temporary passes, but also when she was inside the hospital environment, including times when she was supposedly under constant supervision.

During the period in issue, S was a patient in two different hospitals, the Janeway Children's Health and Rehabilitation Centre, a pediatric facility, and the Waterford Hospital, a mental health facility. There was no actual diagnosis, only a reference to 'Borderline Personality Disorder', and the course of S's treatment is not clear. She was given mood-stabilizing drugs, which she took for a time but stopped. On one occasion she discontinued taking the medication because it made her tired and she gained weight. At several points she was considered for out-of-province treatment but this was found to be inappropriate, in part because she was seen as lacking motivation. She was described as a challenging patient, reluctant to take medication or to participate in various treatments. In directing her own course in the hospital, LeBlanc J. stated that "it appears that she has managed, to some degree, the professionals she has been dealing with as opposed to them being able to manage her treatment."[13]

[13] *SJL, supra* note 1 at 13.

Over this time S was detained as an involuntary patient many times under the Newfoundland and Labrador *Mental Health Care and Treatment Act.*[14] In June 2009, the Ethics Panel of the Waterford Hospital criticized her continued isolation, stating that hospital staff believed the standard of care was not being met in S's case, and that a substitute decision-maker was required because S could not give consent to treatment.[15] In November 2009, two psychiatrists refused to certify S. This prompted her mother to apply to Court to prevent her daughter from being discharged.

AC and *Starson*

AC was a challenge to s. 25(8) of the Manitoba *Child and Family Services Act*,[16] which authorizes a court to order medical treatment it considers to be in the "best interests" of a child under the age of 16, taking into account "all relevant" considerations, which may include the child's views. AC argued that this section violated her right to refuse treatment, thus infringing ss. 2(a), 7, and 15 of the *Canadian Charter of Rights and Freedoms*. AC was a teenager, nearly 15-years-old, with Crohn's disease, who was a devout Jehovah's Witness. Six months before her hospitalization, she signed an advanced directive indicating that she would not consent to receiving blood products for medical treatment. She continued to maintain this position throughout the proceedings. When she was admitted to hospital with severe internal bleeding, which doctors believed could result in death or serious bodily harm, the psychiatrists who examined her could find no evidence of mental illness. The trial judge proceeded on the basis that she had capacity. After being apprehended as a child in need of protection under the Manitoba *Child and Family Services Act*, the judge ordered the blood transfusion be administered because it was in her best interest, having regard to all of the circumstances. The majority of the Supreme Court of Canada did not find that the legislation violated the *Charter*.[17] However, the judges differed over the significance of a teenager's views, with five judges agreeing that it is necessary to respect those views if, after a careful and sophisticated analysis, the court finds the individual has the necessary level of maturity to make the particular decision.[18]

Starson, based on the interpretation and application of s. 4(1) of the Ontario *Health Care Consent Act*,[19] was about the nature of competence and the right of an

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[14] SNL 2006, c M-9.1. On three previous occasions S "has been certified under the *Mental Health Care and Treatment Act* by two psychiatrists, the last being on July 29, 2009 until August 20, 2009. There were six occasions when she has been certified on one signature." However, on "November 30, 2009 and December 2, 2009, S was found to not meet the criteria required for certification under the *Act*." *SJL supra* note 1 at 27.

[15] *SJL, ibid* at 22.

[16] CCSM, c C80.

[17] Note the strong Dissent by Binnie J who argued the value of autonomy: *AC, supra* note 7 starting at 162.

[18] *Ibid* at 121.

[19] SO 1996, c 2, sched A.

adult with a mental disability to refuse treatment. Starson was a man diagnosed with a bipolar disorder. He preferred to be known as Professor Starson, an eminent physicist, and had frequently been detained in mental hospitals in Canada and the United States. Although the doctors recommended he take a series of neuroleptic medication for his condition, he did not want the treatment because it interfered with his thinking. The *Health Care Consent Act* addresses the difficult question of when a person with a mental illness can refuse treatment. The Court mentioned three underlying values involved: the right to autonomy; the availability of effective medical treatment; and, in some instances, societal protection.[20] Competence relates to capacity and does not depend on acknowledging the existence of a psychiatric condition. Since Starson was able to understand the information relevant to making a treatment decision, and was able to appreciate the relatively foreseeable consequences of the decision, the Majority found he was competent to refuse treatment. Best interests did not have any place in the decision.

Decision of LeBlanc J.

LeBlanc J. set out the law on competence by referring first to the provincial *Age of Majority Act,* which makes the threshold for adulthood 19 years in Newfoundland.[21] However, in Newfoundland and Labrador, a 16-year-old can be presumed competent to consent to medical treatment under the *Advance Health Care Directives Act.*[22] A person even younger than 16 years could also be found competent under common law doctrine of the "mature minor". Nonetheless, where a person is less than the age of majority and not mature enough to make a decision, a court may intervene. In such cases the court may exercise its *parens patriae* jurisdiction to interfere with a treatment decision or to order treatment.

LeBlanc J. relied on the two-part test for competence to consent to health care matters that was developed in *Starson.*[23] First, the person must have the capacity to understand the pertinent information, requiring the cognitive ability to "process, retain and understand".[24] This means that the individual can process intellectually, information about the treatment and its impact. Second, the person must be able to appreciate the reasonably foreseeable consequences of the decision. [25] That is, the person is able to apply the information to his or her own circumstances, which requires both a cognitive and affective component. LeBlanc J. referred to three common clinical indicators offered by McLachlin C.J. in *Starson* as a framework for assessing the appreciation component: the ability to acknowledge that the condition for which treatment is proposed may affect him or her; the ability to assess that the

[20] *Starson, supra* note 8 at 6.
[21] SNL 1995, c A-4.2, s 2.
[22] SNL 1995, c A-4.1, s 7.
[23] *Supra* note 8.
[24] *Ibid* at 78.
[25] *Ibid.*

proposed treatment decision could affect him or her; and that the choice is not substantially based on a delusional belief.[26]

LeBlanc J. also relied on the idea of maturity developed in *AC*.[27] The Court described this as a "sliding scale", in which deference is to be given to the adolescent's wishes in light of maturity and the seriousness of the consequences.[28] Abella J. for the majority in *AC* stressed the difficulty of assessing maturity.[29] The "best interests standard" provides a perspective for the courts to act in cases of vulnerable individuals, but must be applied consistent with the individual's level of maturity. While *AC* dealt with the idea of maturity in the context of legislation concerned with statutory presumptions about age and capacity, LeBlanc J. said that this analysis about maturity applies to any person who has not reached the age of majority, regardless of statutory or common law presumptions.[30]

As a 16-year-old, S had not reached the age of majority. However, she was presumed competent to make her own health care decisions unless the court found she was not. Applying the two-part competence test from *Starson*, LeBlanc J. concluded that S's presumed competence is not rebutted on the first part of the test. Based on her cognitive ability to "process, retain and understand" pertinent information, LeBlanc J. found that S was able to understand the information relevant to making a treatment decision.[31] Although S did not agree with her diagnosis, she recognized that she had certain symptoms that were consistent with Borderline Personality Disorder, understood treatment options, and had the ability to understand possible risks and side effects. However, LeBlanc J. was not satisfied that S had the ability to fully appreciate the full extent of her decision, the second prong of the capacity test. Put simply, "her mental disorder prevents [S] from having the ability to appreciate the reasonably foreseeable consequences of her decision to accept treatment or not",[32] despite the poor prognosis of any treatment for S's condition. On some occasions she was unable to control the urge to harm herself, described as a manifestation of her condition. Her lack of motivation to seek and participate in treatment was a reflection of her condition, not a conscious and controllable choice. Thus, the presumption that S was competent to make her own health care decisions was rebutted.

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[26] *SJL, supra* note 1 at 43. LeBlanc J. points out that McLachlin C.J. was not in the majority in *Starson* but concludes that she was not in disagreement about the legal test for competence expressed in the majority opinion, but rather in the application of the test.
[27] *Ibid* at 46.
[28] *AC, supra* note 7 at 22.
[29] *Ibid* at 4.
[30] *SJL,* supra note 1 at 46.
[31] *Ibid* at 82.
[32] *Ibid* at 89.

Despite the finding that she was not competent, LeBlanc J. went on to discuss the best interests standard.[33] He concluded that he would have ordered treatment in her best interests under the *parens patriae* jurisdiction regardless of the competency finding because he had concerns about her level of maturity.[34] Referring to the sliding scale of the importance of maturity described in *AC*, the decision not to accept treatment in this case could well result in self-injury or death, either deliberately or accidentally.

Comment

Why refer to a trial court decision which has limited application? And why refer to this one in particular? In practical terms, these courts decide these questions. Whether a child should be given medical treatment contrary to the wishes of the individual or the family, is often brought in conjunction with an application to apprehend a child in need of protection under provincial child welfare law. Such cases tend to be urgent and there is little likelihood of appeal.

The facts in *SJL* are unique and extreme, thus highlighting the conflicting interests involved. In many cases where the courts are involved because a minor refuses treatment, the refusal was based on religious beliefs and the young person was backed up by the family against an application made by the state. Here, the parent's wishes did not align with the child's. S's refusal of treatment was not rooted in faith, as is commonly the case with medical refusals by children, and is a complicating factor because of the constitutional right to freedom of religion.[35] Whereas cases tend to involve physical illnesses and discrete treatments such as blood transfusions or chemotherapy, S's condition was not purely physical, but also psychiatric in nature. The type of treatment, its prognosis, and its prior effectiveness were all ambiguous. In the past, the proposed treatment kept her alive, but not safe from injury. In this decision we see the tensions among definitions of competence, recognition of evolving autonomy, adolescent rebelliousness, and the court's role in protecting vulnerable persons.

Despite the importance of each of those considerations, the inherent tensions among them, and the important principles articulated by the Supreme Court of Canada in *AC* and *Starson*, the best interest principle overrides those competing interests. LeBlanc J. paid careful attention to the test for competence, its application

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[33] *Ibid* at 92 and 93.

[34] *Ibid* at 94.

[35] See *Y(A), Re* (1993), 111 NFLD & PEIR 91, 384 APR 91 (PEI SC (TD)) [*Y(A)*] where a 15-year-old boy, JH, who had cancer and a poor prognosis, refused blood transfusions on religious grounds. He was declared a mature minor and found not to be a child in need of protection. See also *BH supra* note 4; *D (TT), Re* (1999), 171 DLR (4th) 761, 176 Sask R 152 (Sask QB) [*D (TT)*]; *H(T) v Children's Aid Society of Metropolitan Toronto* (1996), 138 DLR (4th) 144, 37 CRR (2d) 270 (Ont Ct J (Gen Div)); *B(R) v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315, 122 DLR (4th) 1.

to the facts, and S's particular characteristics, and found S not competent. Although the Court needed to pay some attention to S's opinion, it was not to assume that she was the right person to decide what was best unless she showed enough maturity in all of the circumstances, because the concept of maturity overrides competence.[36] S did not show the requisite level of maturity. This was sufficient to decide the case, but the Court went on to evaluate what was in the best interest of S.

LeBlanc J. adopted a two-step inquiry that began with an assessment of competence, followed by a best interest assessment, which would be determinative, regardless of the competence inquiry.[37] In my view, this protective approach was correct. As in *AC,* where the trial judge proceeded on the assumption that she had capacity, but ordered treatment in her best interest under the Manitoba legislation anyway, the findings on capacity tend not to decide the matter. The result of the competence inquiry is relevant only as a factor in determining the broader question of what is in the best interest of the young person.[38]

(A) The Importance of a Life and Death Context

It is clear that these cases arise from a particular context: that a person's choices are reasonably likely to end her life.[39] The court substitutes its view regarding best interests because of the belief that it is best for the minor to live. In this case it is ambiguous whether S intended to kill herself, but she was clearly engaged in life-threatening behaviour.[40]

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[36] A considerable body of social science literature to support the position that cognitive capacity does not necessarily indicate the necessary maturity to make important medical decisions. See for example J Fortin, *Children's Rights and the Developing Law,* 2nd ed (London: Cambridge University Press, 2003) at 73; L Weithorn & S Campbell, "The Competency of Children and Adolescents to Make Informed Treatment Decisions" (1982), 53 Child Development 1589; C Lewis, "A Comparison of Minors' and Adults' Pregnancy Decisions" (1980), 50 American Journal of Orthopsychiatry 446; B Ambuel & J Rappaport, "Developmental Trends in Adolescents: Psychological and Legal Competence to Consent to Abortion" (1992), 16 Law & Human Behaviour 129; L Friedman Ross, "Health Care Decisionmaking by Children: Is It in Their Best Interest?" in Michael Freeman, ed, *Children, Medicine and the Law* (Dartmouth: Ashgate Pub Ltd, 2005) 487 at 488-89.

[37] The stark alternatives for children of having rights to autonomy versus decisions made in their best interest is only one way of looking at legal principles applied to children, and is oversimplified. For example, T Campbell, in "The Rights of the Minor: As Person, as Child, as Juvenile, as Future Adult" (1992) 6 Int'l JL Pol'y & Fam 1, suggests that children's rights should be understood in relation to developmental processes. Depending on context, the legal interests of young persons may be identical to all human beings, or reflect their emerging autonomy, or their interest as future adults, or those interests that are unique to childhood.

[38] This is consistent with the view in *AC, supra* note 7 at 116.

[39] Some jurisdictions acknowledge a statutory recognition of a type of age-tiered consent provision that takes context into account. See for example the Ontario *Child and Family Services Act*, RSO 1990, c C.11, ss 27(1), 27(2), 28, 131(4)(b) and 132(1).

[40] Put another way, S was not seeking permission to die.

In *AC,* Abella J. sets out the position of some scholars who suggest that minors should be permitted to exercise their autonomy interests only to the extent that this does not threaten their lives or health.[41] This is completely consistent with the outcomes in these types of cases. It would be clearer and more honest to acknowledge this unique context in the law.[42] This would mean that in the narrow category of cases where the decision of a minor is likely to be fatal, there would be no decisive intermediary processes such as assessment of competence or maturity. Such cases would be decided in the best interest of the minor in order to protect his or her life.

A life and death context is quite different from the context the mature minor principle came from. In *Gillick v. West Norfolk and Wisbech Area Health Authority,*[43] the House of Lords said that minors could make medical decisions without their parents' approval or knowledge, as long as the minor could fully understand the nature of the decision. In that case, the issue involved access to information about contraception from a medical doctor. The effect was to facilitate medical treatment that was recommended by doctors and desired by the minor but opposed by the parents.[44] Although the decision in *Gillick* was made during a period of increased attention to rights generally and children specifically, it was made in a protective framework that did not equate a competent minor with an adult. Rather, it acknowledged 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."[45] However, the right of teenagers to access medical care in the context of sexual activity or reproduction is different from the life and death context of *SJL.*[46] In the reproductive context there may be a particular need for autonomy, that is to get a teenager information about birth control. Arguably, autonomy and best interests coincide. In this case, we are worried that S is going to end her own life deliberately, or hurt herself so seriously, even if not intentionally, that she would die. Unlike the reproductive context, autonomy and best interests probably diverge when the decision concerns life-saving measures.[47]

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[41] *AC, supra* note 7 starting at 70.

[42] S Harmon, "Body Blow: Mature Minors and the Supreme Court of Canada's Decision in A.C. v. Manitoba" (2010) 4:1 McGill LJ 93.

[43] [1985] 33 WLR 830, [1986] AC 112 (HL) [*Gillick*].

[44] *Ibid.*

[45] *Ibid* at 173.

[46] In the *Gillick* decision, granting some autonomy to the mature minor does not remove the *parens patriae* power to override the decision. See *Re R (A Minor) (Wardship: Consent to Treatment)*, [1991] 4 All ER 177, [1991] 3 WLR 59 (Eng CA), and *Re W (A Minor) (Medical Treatment:Court's Jurisdiction)*, [1992] 4 All ER 627, [1992] 2 WLR 758 (CA). Although an adolescent may be granted autonomy to make decisions in a medical context, parental obligations continue until the minor reaches the age of majority: *C (JS) v Wren* (1986), 76 AR 115, 49 Alta LR (2d) 289 (CA).

[47] The capacity to refuse treatment has been upheld where the court agrees that the refusal is in the minor's best interest. See *AC, supra* note 7 at 64 referring to *Y(A)* and *Walker* where there was both a poor prognosis with treatment and the expectation of emotional trauma associated with the unwanted procedure.

(B) Chronological Age

For many activities, chronological age creates a bright line between childhood and adulthood. Laws about serving alcohol, renting cars, and requiring school attendance divide people into children and adults strictly on the basis of chronological age. In addition to the demarcation between childhood and adulthood, various systems separate the teenage period into older and younger adolescence. For example, the British Columbia *Employment Assistance Act*[48] allows direct welfare payments to older teenagers who are not living with their families, and the *Marriage Act*[49] requires parental or judicial consent to marry depending on the age of a teenager. Only older youth can be transferred to adult court under the *Youth Criminal Justice Act*.[50] These differentiations acknowledge that the typical 12-year-old and 17-year-old are developmentally quite different. With increased experience, cognitive capacity and commensurate responsibility in the older adolescent, these gradations recognize evolving independence and autonomy interests in the older group.

S had not yet reached the age of majority in Newfoundland and Labrador. While, as a 16-year-old, she was presumed competent to make healthcare decisions, this presumption was rebutted. Although the competence inquiry decided the case, LeBlanc J. went on to a best interest analysis. LeBlanc J. said that S could not make her own decision, in part because she had been hospitalized so often.[51] For two years she had resided mostly in an institutional setting, separated from family and friends, and thereby not experiencing life in the same manner as other individuals of her age.

What is it about adolescence that justifies the different approach taken from adults? Why reject the right to autonomy in favour of best interests, regardless of perceived cognitive competence? Dominant ideas about youth suggest that young people are easily influenced and swayed by others because of their family relationships, economic position and stage of development. As a general rule, young people are seen as too dependent to be certain that an opinion expressed is well-reasoned and truly their own.[52] For example, teenagers often live at home, thus relying on their families for economic and social support. There is a particular suspicion about the independence of a child's opinion when his or her family holds unpopular views. In particular, the courts worry that the influence of a family's religious belief or cultural practices may detract from the independent decision-making of a minor, such as the refusal of blood transfusions by minors from families of Jehovah's Witnesses. This doubt lingers even where there is evidence that the

[48] SBC 2002, c 40.
[49] RSBC 1996, c 282.
[50] SC 2002, c 1.
[51] *SJL, supra* note 1 at 93.
[52] In *D (TT), supra* note 37, the court ordered treatment over a 13-year-old's decision to refuse surgery and chemotherapy, finding the refusal not to be voluntary because of the inordinate influence of his father who misled him about the nature of his condition.

minor is committed to religious beliefs quite separately from the family, as was the case in *AC*.[53]

The fact that young persons have less experience in the world than older persons is an important difference. This naïveté is significant in determining appropriate legal standards and processes. For example, stemming from their age, young people are entitled to a presumption of diminished moral blameworthiness in the criminal justice context, because of their lesser maturity and reduced capacity for moral judgment.[54] For this reason, there are separate legal and sentencing regimes for minors. To make a decision about medical treatment that is irreversible and potentially self-destructive, the decision-maker needs assurance that the individual has a depth and breadth of experience about life. This is obviously limited by chronological age. LeBlanc J. found that S was particularly sheltered during her early teenage years, thus putting her at a disadvantage when it came to judgment and maturity. She was not the typical 16-year-old contemplated in the presumption. Thus, social responsibility requires that we find a way for the courts to preserve the welfare of young persons through its *parens patriae* role in these circumstances.

Once a person is defined as an adult, the right to autonomy usually trumps the social responsibility to keep people from making dangerous medical decisions, and the law does not hinder the medical decisions of competent adults.[55] However, outside of the courtroom we usually do not stand by passively and watch an adult commit suicide, as when the individual holds a gun to his head or threatens to jump from a roof. There is an attempt to stop such actions, which may involve enlisting help from the police.[56] However, when the issue is constructed as a medical choice, even if it is virtually certain to result in death, the law takes a hands-off approach. Some would question this collective social choice, pointing to groups of vulnerable competent adults who should be protected when making life and death decisions.[57] Although the assessment of maturity before adulthood is highly individualized and depends on circumstances, the line between childhood and adulthood is generally strict. It is irrelevant whether the adult is easily influenced, dependent on family or friends, or inexperienced.

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[53] *Supra* note 7.

[54] *R v B(D)*, 2008 SCC 25, [2008] 2 SCR 3 at 41.

[55] The rebuttable common-law presumption is that an adult is competent with the right to refuse life-saving treatment. 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.

[56] This is so despite the fact that suicide is not against the law.

[57] Such a discussion is beyond the scope of this paper but we could as easily ask why we do not interfere with such decisions for adults, as why we do interfere with minors.

(C) Impact of a Psychiatric Diagnosis

S's mental health issues brought her into the psychiatric system, which then provided both a trigger and a mechanism for intervention in this case. The thrust of this application was to confine S to hospital. Although such detention is a significant deprivation of liberty,[58] it was very unclear what other suggestions were made about treatment during her stay in hospital. Everyone was concerned about S and wanted to see her supervised strictly so that she did not harm herself. This was characterized as a treatment decision. This construction was possible because she was already involved in the psychiatric system. At the time of this application psychiatrists would not certify her under provincial mental health legislation, although they had committed her involuntarily in the past. If she were certified, she could be treated without her consent.[59]

Although she had treatment for depression in the past, LeBlanc J. found that S's main diagnosis was Borderline Personality Disorder.[60] LeBlanc J. recognized that there was less medical certainty about diagnosis and proven treatment options where refusing to accept treatment relates to a condition of the mind rather than a physical ailment.[61] As well, he was aware that in cases involving mental rather than physical illness, there are likely to be longer orders for detention and treatment.[62] While acknowledging that the diagnosis of a major mental disorder is far from a "perfect science", LeBlanc J. found that 'Borderline Personality Disorder' is historically difficult to treat or "untreatable."[63] With this condition, hospitalization is recommended only for the stabilization of acute episodes, but this leads to deterioration in most patients.[64] Long-term hospitalization has not shown a decrease in suicidal or other self-injurious behaviour.[65] Recognizing the difficulties of keeping

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[58] There are other examples of legislation aimed specifically to detain teenagers involved in dangerous activities. Several jurisdictions have passed legislation allowing for confinement of teenagers at risk of sexual exploitation (see, for example, Alberta's *Protection of Sexually Exploited Children Act*, RSA 2000, c P-30.3, s 2), while legislation in other jurisdictions concentrates on the adults who are engaged in the exploitation of young persons. The following jurisdictions have passed legislation allowing for the apprehension of young people involved with drug abuse: Alberta (*Protection of Children Abusing Drugs Act*, SA 2005, c P-27.5); Manitoba (*The Youth Drug Stabilization (Support for Parents) Act*, CCSM, c Y50); and Saskatchewan (*Youth Drug Detoxification and Stabilization Act*, SS 2005, c Y-1.1).

[59] Some mental health legislation, including Newfoundland and Labrador, do not require an investigation of the individual's capacity to make the decision once committed as an involuntary patient although the criteria for committal include a reference to treatment. Section 17(1)(b)(ii)(B) of the *Mental Health Care and Treatment Act*, *supra* note 12, requires for a certificate of involuntary admission that, as a result of a mental disorder, a person "is unable to fully appreciate the nature and consequences of the mental disorder or to make an informed decision regarding his or her need for treatment or care and supervision."

[60] *SLJ*, *supra* note 1 at 58.

[61] *Ibid* at 3. Binnie J, in his dissent in *AC*, notes in a reference to *Starson* that policies about children and adults with psychiatric conditions can be similar: "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." *AC*, *supra* note 7 at 194.

[62] *SJL*, *ibid.*

[63] *Ibid* at 59 and 61.

[64] *Ibid* at 59.

[65] *Ibid.*

S in a hospital for a lengthy period, and the potential harm of the hospitalization itself, Le Blanc J ordered S to be detained in hospital for two weeks after which the order would be reviewed.[66] At that time the Court would consider other options such as community placement, out-of-province treatment, and who should be her legal guardian or substitute decision maker.

In fact, S had harmed herself both while she was supervised, and while she was not. Arguably, little would be accomplished by a further two-week detention. However, the hospital was likely a safer place where she could get immediate medical attention for acts of self-harm. While this was not a long-term solution, and substituting confinement for treatment is dubious, it is probably the best that could be done for her in all the circumstances.

CONCLUSION

Like many other cases involving life and death medical decisions, the emphasis in *SJL* is an attempt to preserve S's life by using the best interests principle, rather than autonomy, which could well have resulted in her death.[67] In my view this was the correct approach, with a competence inquiry serving only to provide information on what was in S's best interest.

While I argue that this is the preferred approach, I recognize that there are pitfalls with using best interests as the paramount principle. A best interests principle could easily be overused in our efforts to protect minors from unnecessary pain and trouble in their lives that would extend to situations where the potential outcomes are less dire than they were in *SJL*, such as the circumstances in *Gillick*. The danger is overprotecting minors by deciding for them in situations where that is not necessary. The application of best interests is a wide, vague and potentially tempting tool. In light of extensive critiques, developed mainly in the context of family law,[68] that the best interests principle is paternalistic, indeterminate,[69] subject to bias,[70] tends to treat children as objects, and denies them agency, we worry that minors would be denied the opportunity to make mistakes, learn from them, and develop an adult

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[66] *Ibid* at 105.

[67] *Ibid* at 94.

[68] F Kelly, in "Conceptualising the child through an ethic of care: lessons for family" (2005) 4:1 International Journal of Law in Context 375, goes beyond the traditional debate between rights and best interests in the context of family law.

[69] RH Mnookin, "Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy" (1975) 39 *Law & Contemp Probs* 226.

[70] J Mosoff, "Motherhood, Madness, and Law" (1995) 45 UTLJ 107; M Kline, "Complicating the Ideology of Motherhood: Child Welfare Law and First Nation Women" (1993) 18 QULJ 306; M Kline, "Child Welfare, "Best Interest of the Child" Ideology, and First Nations" (1992) 20 OHLJ 375.

sense of competence.[71] The balance is to allow children to make mistakes, but not those with fatal consequences.

Like any adolescent, S was in the process of evolving into adulthood when her autonomy would be recognized,[72] but deciding this case on the basis of her autonomy interests would risk her ever getting to adulthood. Although confinement has not kept her entirely safe in the past, it has kept her alive and given her access to immediate medical care. As was the case in *AC*, the judge decided not to respect the wishes of S to leave the hospital[73] because it was not in her best interest.

While there are some risks to an unbridled use of the best interest principle in medical decisions involving teenagers, protection is always appropriate when the stakes are life and death. The history of such cases as outlined by Abella J. in *AC* suggests that the courts have taken this general approach.[74] She cites no cases in Canada, England, Australia, or the United States where the mature minor principle has been used to legitimate the refusal of life-saving treatment. I recognize that the hospitalization ordered in this case is not as clearly life-saving as a blood transfusion or organ transplant might be. However, we know that S was engaging in life-threatening behaviours for reasons that remain unclear. In this difficult context, continued hospitalization may be the closest approximation of life-saving treatment available, given her complex psychiatric background. In a humane society that should protect children, this is the appropriate answer.

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[71] S Van Praagh, "Adolescence, Autonomy and Harry Potter: the Child as Decision-Maker" (2005) 4:1 International Journal of Law in Context 335.

[72] However, as an adult in this jurisdiction, she would not have the right to refuse psychiatric treatment if she was committed involuntarily.

[73] *SJL, supra* note 1 at 104.

[74] *AC, supra* note 7 starting at 48.