

Medical care disputes and the best interests of the child: integrating the medical evidence

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I. THE BEST INTERESTS OF THE CHILD

The best interests of children are a fundamental responsibility of society.¹

THIS IS A STATUTORY DECLARATION of what most would consider axiomatic. Once society, through its courts, has chosen to intervene in a child's care, the disposition of the resulting dispute should be resolved in the child's best interests:

I would therefore conclude that in the case at bar the dominant consideration to which all other considerations must remain subordinate must be the welfare of the child....Where it is clear the welfare of the child requires it, however, [parental claims] must be set aside.²

Some legislatures have clearly made this the paramount consideration:

This Act shall be construed and applied so that in matters arising under it the interests of the child affected shall be the paramount consideration, and where the rights or wishes of a parent or other person and the child conflict the best interests of the child shall prevail.³

In the administration and interpretation of this Act the best interests of the child shall be the paramount consideration.⁴

Despite these pronouncements, within the total scope of child protection there remain a few difficulties that prevent one from being too categorical that the issue is that straightforward. Nevertheless, as will be noted below, when one focuses in on disputes regarding medical care, the ultimate test may well remain the child's best interests.

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1 *The Child and Family Services Act*, S.M. 1985, c. 8, C.C.S.M., C80, "Declaration of Principles."

2 *King v. Low*, [1985] 1 S.C.R. 87.

3 *Children's Act*, R.S.Y. 1986, c.22, s. 1.

4 *Family and Child Services Act*, R.S.P.E.I. 1974, c. F-2.01, s. 2.

But first, courts have to develop some mechanism to decide what is in a child's best interest. They are asked to do so when a parent has not acted to the same standard. Although we can define the extremes, we ask parents to make the appropriate decisions without spelling out what constitutes "best interests." Similarly courts, when asked, may have difficulty articulating the factors that go into making such an assessment. So, on the one hand, we can generally say to parents that they should undertake appropriate medical treatment if their child needs it. It certainly must be in a child's best interests to be made well if ill. Decisions, sometimes difficult, may need to be made by a parent when there is an element of risk, but seldom would a parent apply the "substituted judgment" approach; that is, to decide the case as the child would if he could, an approach that has been argued as one that the courts should adopt.⁵ When, through the avenues to be discussed later, the issue comes to court, it never is that simple. Sometimes it is the decision itself that is more difficult, but more often it is because the parents, and perhaps the child, who find themselves at odds with some value held by society in general. Since law is about resolving conflicts, and making sense out of them, mechanisms and approaches have been developed that courts appear to use when they make such decisions.

Besides the difficulty in formulating the test, there may even be a question as to whether and when the best interests test should apply. This is because these disputes regarding medical care arise in the broader context of child protection legislation that also covers other issues such as child abuse, neglect, and abandonment. Thus, in Manitoba, the legislation may, at first look, appear to preclude considering the child's best interests:

The best interests of the child shall be the paramount consideration of the director, 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...*⁶ [emphasis added].

In the same vein, other provinces have different wording that seems to delay the application of the best interests approach until after the child has been found in need of protection.⁷ Thus it would seem that some other test must apply in the early part of an assessment, such that one is not simply balancing benefits and risks at every stage of the dispute.

5 E-H.W. Kluge, "In the Matter of Stephen Dawson: Right v. Duty of Health Care" (1983) 129 Can. Med. Assoc. J. 116.

6 *Supra*, note 1, s.2.

7 *Child and Family Services Act*, 1984, S.O. 1984, c. 55, s. 53(1); *The Child Welfare Act*, 1972, S.N. 1972, c. 37, s. 2.1.

It is submitted that this "non-best interests" approach is relevant to potential abuse situations but not for most medical care dispute cases. First, consider that the whole scope of child protection has evolved from considering societal intervention only at the point of parental criminality to the view expressed in the opening statement; namely, that society should look out for the interests of all children.⁸ Child protection legislation, as reflected in recent revisions, has placed the issue somewhere between the following two extremes:

The view of the child's welfare conceives it to lie, first within the warmth and security of the home provided by his parents.⁹

And,

The issue is not what is justice to the parents but what is for the welfare of the child, and the welfare of the child can best be weighed by disregarding entirely any concept of claim, just or unjust, on the part of the parents.¹⁰

This shift from parental rights to the best interests of the child occurred at different rates when one compares custody disputes to neglect and abandonment cases, but in any event, as the statutory provisions changed, case law reiterated concern that the issue had not yet quite shifted all the way:

Whether this child is in need of protection is something much narrower than the paramount issue of what is in the best interest of the child.¹¹

...[T]he community ought not to interfere merely because our institutions may be able to offer a greater opportunity to the children to achieve their potential. Society's interference in the natural family is only justified when the level of care of the children falls below that which no child in this country should be subjected to.¹²

However, even in Manitoba, where statutory language seems to make it clear that the best interests of the child are not the first thing to consider, clear expressions of that, even in abuse and neglect cases, become less easy to find. Thus Twaddle J.A., sitting alone on a request for an agency's continuing custody pending an appeal, noted that such a request should be considered in the child's best interests. However, that

8 V. Jennifer Mackinnon, "Best Interests of the Child in Protection Hearings: A Move Away from Parental Rights?" (1980) 14 R.F.L. (2d) 119.

9 *Hepton v. Maat*, [1957] S.C.R. 606 at 607.

10 *Barnett v. Barnett* (1973), 21 F.L.R. 335 at 343 (Aust. C.A.).

11 *Re Kossakowski*, (21 July 1976), (Ont. Prov. Ct.), cited in MacKinnon, *supra*, note 8.

12 *Re Brown* (1975), 21 R.F.L. 315 at 319 (Ont. Co. Ct.).

would not be the test at the initial determination of the need for protection, nor would it be on the eventual appeal.¹³ In contrast, two years later, a different panel, by majority, held that the child's best interests were the issue to be addressed on appeal, an issue later not clearly considered on appeal in the Supreme Court.¹⁴

That ruling notwithstanding, there are good reasons why a bare best interests approach should not be the test in many abuse and neglect situations. Thus, when a child was removed from her mother because of repeated neglect, her natural father showed up to contest the agency's application for permanent guardianship. Schwartz J. noted:

The court need not find that J.'s best interests will be served by placing her with the applicant, V.R. It merely is obliged to find she is not in need of protection from him.¹⁵

While it may not be categorically in the child's best interests to go with her father as opposed to adoption, as long as no risk to her could be shown in that arrangement, the court would not allow the agency to intervene.

The primary issue therefore is the finding that the child is in need of protection. As will be noted below, this entails a finding that the child meets the various criteria contained in the statute. Short of such a finding, the child's best interests will not be an issue. Nevertheless, regarding medical care disputes, the best interests test is still operative. Generally, the statutes allow a finding of the need for protection when medical care should be provided but is not. To answer the question the court will really have to determine whether the proposed treatment is in the child's best interests. The question may be phrased differently: is the treatment necessary? is the proper care being provided? It is submitted a court still has to consider the child's best interest, in a broad context, to answer the question posed by statute. The decision necessary is qualitatively different from that necessary in an abuse or neglect case. There, the situation is being compared to a minimum acceptable standard, whatever the best interests of the child might dictate.

One could envisage a hypothetical situation where the best interests test would not apply in a medical dispute case. The condition needing treatment may be so benign that, even if such treatment was better for

13 *Children's Aid Society of Western Manitoba v. Demery* (1986), 41 Man. R. (2d) 258 (C.A.).

14 *B.B. v. Director of Child and Family Services* (1988), 51 Man. R. 245 (C.A.), rev'd in part [1989] 1 S.C.R. 291.

15 *Child and Family Services of Central Winnipeg v. V.E.R. and M.L.W.* (1986), 45 Man. R.(2d) 222 at 232 (Q.B.).

the child than no treatment, a court would not intervene in the parental decision. In practice, the issue would likely never come to court. Even at that, when less serious cases appeared elsewhere, courts have still reviewed them looking at the child's best interests.

Keeping in mind the difficulty that this backdrop of child abuse places on these cases, it is still submitted that sooner or later courts consider the child's best interests. Other mechanisms or formulae may be acknowledged, but, it is suggested, these are more apparent than real. Rather, in these cases the facts, as they come out, are so important, they almost speak for themselves. There are some fact situations where, despite any argument, the decision can be predicted with near certainty. Where the issue is less obvious, it is clear that the presentation and enhancement of the facts by the parties define the result more than the claimed issues or principles that appear to be at stake. By looking at how different fact situations come before a court, it is hoped to highlight how these cases may really be decided.

II. THE SOURCES OF CONFLICT

BECAUSE OF THE PUBLICITY that surrounds the most notorious of these cases, the scenarios are familiar. A child may appear in need of treatment to which the parents object, often for religious reasons. Or the objection may stem from a particular quality of the child, such as mental retardation, chronic disease, or a poor prognosis. But what specific factors lead to this collision course between medical opinion and parental wishes?

At one extreme are the apparent "life-or-death" transfusion cases. When confronted with a child whose condition, in their opinion, requires or is likely to require a transfusion, almost all physicians will not "honour" a parents' refusal.¹⁶ If that is the situation, it just becomes "unacceptable" to the physician (and in most cases for the court) to put the child at grave risk by not being able to transfuse. Hence, a physician, when confronted with parental beliefs that are irreconcilable with what appears necessary for the child, will seek outside intervention.

Another level of difficulty occurs when the parents will only accept an alternative treatment that is not available locally. In the case of Jehovah's Witnesses, this is now a frequent response to the suggestion of a transfusion. The issue often involves the need for blood during proposed surgery. Assuming the surgery is necessary, and the parents gen-

16 William M. Tierney *et al.*, "Jehovah's Witnesses and Blood Transfusion: Physicians' Attitudes and Legal Precedents" (1984) 77 S. Med. J. 473.

erally agree that it is, the surgeon, recognizing the risks inherent in the procedure, will refuse to proceed until blood is allowed. The parents will argue that the surgery can be done without transfusion, if not locally, then elsewhere. Successful reports of "bloodless" surgery will be advanced as evidence of the "enlightened" approach elsewhere. However, it is clearly one thing to consider the results of elective surgery from a large centre with patients who, if not completely healthy, are at least as prepared in advance as possible.¹⁷ It is quite another matter to consider this an option in a child in urgent need of intervention, whether in a large centre or not.¹⁸ In other words, the physician may conclude there is no real alternative to legal intervention.

The more complicated situation occurs with the child whose underlying condition affects the benefits-risks balance, at least in some eyes. But first those cases that do end up in court have to be put in context. Physicians will not recommend or pursue aggressive life-prolonging treatment in each and every patient they encounter. A reasonable reflection of the general view could be as follows:

A primary role of medicine is to prolong life but not to unthinkingly prolong the dying process. Thus, under the following circumstances there are exceptions to the general duty of providing life-sustaining or life-prolonging treatment.

- When there is irreversible progression of disease, and death is imminent.
- When treatment will clearly be ineffective or harmful.
- When life will be severely shortened regardless of treatment and when nontreatment will allow a greater of caring and comfort.
- When the patient's life will be filled with intolerable and intractable pain and suffering.¹⁹

Here we are usually dealing with an acquired condition, such as cancer that is in its end-stages, or a congenital condition that is known to have a hopeless outlook. Note that there is no mention of withholding treatment on the basis of the "quality" of life, in the sense that this might affect its "value". At any rate, in most of these severe situations, parents and physicians are in agreement, and society stands back. At least it stands back unless there are other pressures. For instance, as part of a mood of new-right activism in the U.S., an example is provided by the well-publicized case of Baby Jane Doe in New York.²⁰

17 E. Henling *et al.*, "Cardiac Operation for Congenital Heart Disease in Children of Jehovah's Witnesses" (1985) 89 *J. Thoracic & Cardiovascular Surgery* 914.

18 H. Gyles, "Report on the Inquest into the Death of Daniel Kennett" (1987) 8 *Health L. Can.* 52; *Re C.P.L.* (1988), 215 *A.P.R.* 287 (Nfld. S.C.).

19 Bioethics Committee, Canadian Paediatric Society, "Treatment Decisions for Infants and Children" (1986) 135 *Can. Med. Assoc. J.* 447.

20 *Weber v. Stony Brook Hospital*, 467 *N.Y.S.* 2d 685.

A child is born with severe spina bifida. The non-surgical approach is recommended. The parents concur. Third parties, supported by the Reagan administration, claim this is passive euthanasia and seek to intervene. This was eventually rebuffed, and the child did well without surgery.

Nevertheless, it would be naive to think that certain conditions would be ignored by physicians and parents, even if they do not ultimately decide the issue. One of the factors that affects medical attitudes to the wisdom of surgery in an "abnormal" child is the perception of what the child's prospects really are. As attitudes and knowledge changes, medical judgment changes, usually in the direction of treatment, and depending on what parents think and accept, this may or may not increase the chances of conflict. These changing medical attitudes become part of the balance courts may be called on to assess.

The best example of this is Down's syndrome, a not uncommon condition characterized by a typical appearance, varying degrees of mental retardation, and several common malformations. One of these is duodenal atresia, a complete blockage of the small intestine incompatible with survival, but quite curable with surgery. As an example of what used to be done, a review of twenty years of cases in Toronto up until 1971 showed that 27 out of 50 such children did *not* have surgery, all with parental concurrence.²¹ A few years later, a survey was done of paediatricians and paediatric surgeons regarding their response to such a case.²² By comparison, half the paediatricians, but only nineteen per cent of the surgeons would seek to overcome parental objections to surgery. The same response occurred when asked whether they would consent to surgery if it was their own child. The difference between the groups was traced to their different perceptions of the true potential of Down's children. Apparently, the paediatricians were more aware of studies that have shown a greater potential than previously thought. Research had shown that, as these children were being increasingly raised at home, their response to stimulation was noted, their development seemed accelerated,²³ and their potential for independence increased. As a result, denying surgery to a child simply because they have Down's syndrome, is now almost never suggested by physicians

21 D.P. Girvan & C.A. Stephens, "Congenital Intrinsic Duodenal Obstruction: A Twenty-Year Review of Its Surgical Management and Consequences" (1974) 9 J. Pediatric Surgery 833.

22 Anthony Shaw *et al.*, "Ethical Issues in Pediatric Surgery: A National Survey of Pediatricians and Pediatric Surgeons" (1977) 60 Pediatrics 588.

23 Michelle A. Melyn *et al.*, "Mental and Developmental Milestones of Noninstitutionalized Down's Syndrome Children" (1973) 52 Pediatrics 542.

and only rarely by parents.²⁴ Hence, in identifying situations that might provoke conflicts, this greater "aggressiveness" on the part of physicians would seem to create one, but in fact, this change in attitude will eventually be paralleled in society, and thus by parents.

The final scenario and the most difficult one is where future prospects are agreed to be hopeless, such as the profoundly retarded. This brings out some very fundamental issues.²⁵ Nevertheless, as will be discussed below, in these, as in other cases, how the facts are coloured and received can significantly affect a court's decision.

III. JURISDICTION OF THE COURTS

AFTER LOOKING AT THE CONTEXT OF THESE CONFLICTS, it is now useful to look at how they are handled in the public legal arena. Leaving for the moment the mechanism of child protection, authority for judicial intervention comes from two aspects, the *parens patriae* jurisdiction of superior courts and the statutory framework of child protection legislation. It may not be absolutely clear by which avenue a court reaches a result. It seems that authority can be found for the result desired.

A. *Parens patriae*

In a case dealing with sterilization of a retarded adult, the Supreme Court found the mental health statutes unhelpful and addressed the issue in terms of its *parens patriae* jurisdiction.²⁶ La Forest J., in so doing, reviewed the history and development of the concept and stressed the breadth of its jurisdiction, especially in relation to legislation:

... [E]ven where there is legislation in the area, the courts will continue to use the *parens patriae* jurisdiction to deal with un contemplated situations where it appears necessary to do so for the protection of those who fall within its ambit.... [T]he situations in which the courts can act where it is necessary to do so for the protection of mental incompetents and children have never been, and indeed cannot, be defined.²⁷

The courts will not readily assume that it has been removed by legislation where a necessity to protect a person who cannot protect himself.²⁸

It is thus clear that where courts are to assess risks and benefits for mental incompetents and children, they are to resist tying their hands

24 *Re B.*, [1981] 1 W.L.R. 1421 (C.A.); *Re Goyette*, [1983] C.S. 429.

25 *Re S.D.* (1983), 34 R.F.L. (2d) 34 (B.C.S.C.).

26 *Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.).

27 *Supra*, note 26 at 17.

28 *Supra*, note 26 at 28.

by any narrow interpretation of relevant legislation. (Indeed, the Court here rejected any Charter arguments as being applicable to this case.) What is also clear is that the best interests of the ward or child are the focal point:

The discretion is to be exercised for the benefit of that person, not for that of others.... The exercise is confined to doing what is necessary for the benefit and protection of a person like Eve.²⁹

The possible alternative approach of "substituted judgment" was not accepted by the Court: if Eve really could not decide for herself, the Court could not pretend she could.

B. Child protection legislation

As LaForest J. noted in *Eve*, although for some centuries courts have theoretically had a broad power to benefact children in their best interests, they would seldom interfere with parents' rights.³⁰ That began to change with early child protection laws, but even then, the emphasis was on the criminality of the parents' conduct rather than the needs of the child as the trigger for state intervention.³¹

However, during this century, Canadian jurisdictions began to define the issue in terms of the child's needs, particularly the need for protection, but including the need to have medical care provided.³² Now all provinces and territories define the starting point as a finding that a child is "in need of protection"³³ or, alternately, a "child whose security or development may be in danger."³⁴ Such a finding brings the child into the "system" and hence is pivotal in how the state and courts become involved in the matter. It is this finding that is the first issue for legal dispute.

All the statutes define the various circumstances under which a child may be found in need of protection. In addition to abuse, abandonment, and neglect, all include the refusal to provide proper medical care.³⁵ Hence, whether a child has been denied such care may be the first issue the court must assess. Generally, courts have acknowledged a child's need for protection where "proper medical treatment" is not

29 *Supra*, note 26 at 29 and 31.

30 *Re Agar-Ellis* (1883), 24 Ch.D. 317.

31 *Prevention of Cruelty to and Better Protection of Children Act, 1889* (U.K.), 52 & 53 Vict., c. 44.

32 *The Child Welfare Act*, S.M. 1922, c. 2, s. 17(d).

33 *Supra*, note 1, s. 38(1).

34 *Youth Protection Act*, R.S.Q., c. P-34.1, s.2; *Family Services Act*, S.N.B. 1980, c. F-2.2, s. 51.

35 *Supra*, note 1, s. 17(b)(iii).

provided or is refused. The court may have to decide whether an alternative therapy, advocated by the parents, is "proper" in order to deny such a finding. However, courts will only accept alternatives that are practically available.

In a broader sense, it is argued that some of these cases, particularly involving Jehovah's Witnesses patients, do not belong in a child neglect forum at all. These parents are not neglectful in that they are willing to accept all forms of treatment save one. They are still providing all of the child's needs and are entitled to differ with medical opinion on this one issue. In other words, such "good parents" cannot be neglectful.³⁶ This of course, among other things, misses the point of the evolution from the early English statutes to contemporary Canadian child protection legislation. It is not what the parent is, or has done, or is willing to do, but what the child *needs*. If a court finds a child's health at risk because a particular *need* is not met, the sincerity, compassion, or moral standing of the parents do not change that *need* and, as unpleasant as that appears, courts will generally find such a child in need of protection under the statute.

As was noted above it could be argued that a distinction should be drawn between this finding of a need for protection and a decision based on the child's best interest. As was suggested, it seems unlikely a court will make a finding that a child is not in need of protection despite their best interests requiring medical treatment. When that becomes a possibility, a court is more likely to find these best interests lay in non-treatment. The reasons for this contrast was also noted above.

At this point, it would be useful to note briefly a few of the procedural aspects of the legislation. While there is much uniformity, there are also many differences among the approaches taken by the various provinces. Some of these interprovincial differences may be of significance in the constitutional issues that are now inevitably argued in these medical treatment cases.

As noted above, practically speaking, the prerequisite to any order is a finding that the child is in need of protection. Depending on the province, it may or may not be necessary to apprehend the child first, and apprehensions may or may not require warrants. Furthermore, once apprehended, there are differences in what the apprehending agency may authorize without judicial approval. In Manitoba and six other jurisdictions, a court order is not needed to authorize medical

36 J.M. Thomas, "Meeting the Surgical and Ethical Challenge Presented by Jehovah's Witnesses" (1983) 128 Can. Med. Assoc. J. 1153; Myles F. McLellan, "Jehovah's Witnesses and Child Protection Legislation: The Right to Refuse Medical Consent" (1977) 1 Leg. Med. Quart. 37; W. Glen How, "Religion, Medicine, and Law" (1960) 3 Can. Bar J. 365.

treatment.³⁷ In Alberta, medical treatment can be authorized by the agency, with the specific exception of apprehensions for refusing treatment,³⁸ at which point a court order is necessary.³⁹ Nova Scotia and Ontario require court orders but have procedures to expedite them.

All the statutes include mechanisms for the review of apprehensions and orders, as well as notification requirements for apprehensions and hearings. This is noteworthy, because it was found that the lack of such notification provisions in the Newfoundland act⁴⁰ rendered sections of it unconstitutional.⁴¹ The sections were quickly amended.⁴²

The place and time for the best interests test have been already discussed. At the minimum, in Manitoba, it is the test for continuing or reviewing a guardianship or wardship and possibly for appeals on the original finding. Further, unlike other actions with which the legislation is concerned, the best interests test may still be the initially operative one when medical treatment is at issue. Put another way, a court may really be asking itself whether societal protection is in the best interests of the child. If it is, then the initial finding will be made. On the face of the case law, subsequent hearings will also consider the child's best interests, thus conforming with one of the stated statutory principles:

Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society⁴³ [emphasis added].

In addition, definitions of "best interests" are also included; for example, mental, emotional, and physical health are included.⁴⁴ Of further note is the recent Supreme Court decision⁴⁵ that held the definition in the New Brunswick act⁴⁶ to be not exhaustive of the factors, but at the same time to have removed any need to prove parental misconduct, at least as far as the New Brunswick statute was concerned. As L'Heureux-Dube J. reemphasized:

37 *Supra*, note 1, s. 25(1).

38 *Child Welfare Act*, S.A. 1984, c. C-8.1, s. 20(1).

39 *Supra*, note 38, s. 20(2).

40 *Supra*, note 7, s. 11.

41 *Re C.P.L.*, *supra*, note 18.

42 S.N. 1988, c. 47, s. 1.

43 *Supra*, note 1.

44 *Supra*, note 1, s. 2.

45 *N.B. (Min. of Health & Community Services) v. C. (G.C.)*, (1988) 14 R.F.L. (3d) 1 (S.C.C.).

46 *Family Services Act*, S.N.B. 1980, c. F-2.2, s.1.

The determining factor in decisions concerning children is their best interests.⁴⁷

Interestingly, when statutes do discuss religion in this context, it is not the child's religion that is a factor but the child's "religious heritage"⁴⁸ or "the religious faith, if any, in which the child is being raised."⁴⁹ Thus the legislation acknowledges the response courts have taken when it is claimed an infant's religious beliefs are being discriminated against. An infant cannot have a religious belief, only a heritage.⁵⁰

IV. THE LEGAL SCENE

ADMITTEDLY, THE MANNER AND MECHANISMS of apprehensions and child protection have only barely been alluded to, but for the purposes of this article, we shall assume that the dispute has now come to some sort of a hearing. The scene is set against a backdrop of the original conflict with the parents, the inherent power of the court, and the varying legislative approaches. The first issue is whether the child is in need of protection. Statutory language notwithstanding, the best interests of the child may become the ultimate issue. Regardless, the situations are charged with ethical and moral tensions.

However, even at that, it should be kept in mind that the circumstances under which the hearing may take place can vary greatly. There is often an urgency about the situation with cases being heard at all hours,⁵¹ perhaps practically at the bedside.⁵² Sometimes the issue is less emergent, but, nevertheless, there is not the time for more than a few days' delay in the decision.⁵³ Finally, there may be no urgency, because the child had died, and the case is being heard as a judicial review,⁵⁴ and inquest,⁵⁵ or perhaps a criminal trial.⁵⁶ All of this will certainly affect the fact gathering and the way the facts and opinions come out in court.

47 *N.B. v. C.*, *supra*, note 45 at 6.

48 *Supra*, note 46, s. 1(g).

49 *Supra*, note 7, s. 37(3.4).

50 *Re S.E.M.*, (1986) 4 R.F.L. (3d) 363 (Alta.Q.B.).

51 *Pentland v. Pentland* (1978), 20 O.R. (2d) 27 (S.C.).

52 *Supra*, note 18.

53 *Supra*, note 25.

54 *Re C.P.L.*, *supra*, note 18.

55 *Gyles*, *supra*, note 18.

56 *R. v. Cyrenne, Cyrenne, and Cramb* (1981), 62 C.C.C. (2d) 238 (Ont.D.C.); *R. v. Tutton and Tutton* (1985), 18 C.C.C. (3d) 328 (Ont.C.A.), *aff'd* [1989] S.C.J. No. 80.

There are two other issues. Cases may often be heard before an inferior court where jurisdiction may be not as wide as that considered in terms of *parens patriae*. There may also be limits on the remedies available in certain specialized family courts.⁵⁷ In addition, because of their circumstances many cases are never appealed. When appeals are made, they are usually confined to the *post facto* reviews noted above. More importantly, in *Racine*,⁵⁸ the Supreme Court underlined the importance of trial judges' decisions in family law and cautioned appellate courts from interfering with those results. In other words, there is a great deal of importance in how the facts come before the court of first instance, and there will be little chance of recouping losses by appellate argument later.

With all this as a backdrop, the fact finder will attempt to adjudicate a result from the facts as they come before the court. In an attempt to articulate how such decisions are, or should be, made, various writers have developed categories or thresholds for each sub-issue.⁵⁹ One can look at risk-benefit ratios⁶⁰ such as high-gain, low-risk or low-gain, low-risk, etc. Or a series of questions may help clarify the issues:

1. Is the condition serious, yet treatable, and would any delay have an adverse affect?
2. Is the reason for the objection religious, unknown, or actually different from the one stated?
3. If an alternative therapy is proposed, is it medically acceptable, and does it have an equal, or at least substantial chance of success?
4. Are there other factors of possible relevance such as the age or wishes of the child?⁶¹

These are a useful catalogue of the questions that need be answered but, it is submitted that the issues are of very unequal value. The ap-

57 *Re Children's Aid Society of Hamilton-Wentworth and Burrell* (1986), 56 O.R. (2d) 40 (U.F.C.).

58 *Racine v. Woods*, [1983] 2 S.C.R. 173.

59 Angela R. Holder, "Circumstances Warranting Court-Ordered Medical Treatment of Minors", 24 P.O.F. 2d 169; Kenneth J. Rampino, "Power of Court or Other Public Agency to Order Medical Treatment over Parental Religious Objections for Child Whose Life Is not Immediately Endangered", 52 A.L.R. 3d 1118; John C. Williams, "Power of Court or Other Public Agency to Order Medical Treatment for Child over Parental Objections not Based on Religious Grounds", 97 A.L.R. 3d 421; Edward W. Keyserlingk, "Non-Treatment in the Best Interest of the Child: A Case Commentary of *Couture-Jacquet v. Montreal Children's Hospital*" (1987) 32 McGill Law J. 413.

60 Willard Gaylin, "The Competence of Children: No Longer All or None" (1982) 12 Hastings Center Rep. 33.

61 Elizabeth J. Sher, "Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State" (1983) 58 N.Y.U. Law Rev. 157.

proach is really more like an algorithm. For example, if the situation is urgent, life-threatening, and treatable, courts have accepted the need for intervention largely without regard for any other issues. However, the facts must still come out to establish such a scenario. To consider how that occurs, it would be helpful to categorize the situations a little differently. Firstly, there are the life-or-death situations, usually urgent, and, if the child is otherwise normal, usually founded upon a religious objection. Secondly, there may be non-life-threatening situations where the objection may or may not be religious. Thirdly, to be dealt with separately here are the oncology or cancer patients. Fourthly are the "handicapped" children. Finally, special attention need be paid to the concept of mature minors.

A. Life or death

As noted above, if the issue comes down to this, courts have accepted prevailing medical opinion and allowed intervention. This could occur in the case of a congenital malformation needing treatment,⁶² emergency surgery,⁶³ a car accident,⁶⁴ or quite frequently a premature baby. Even at that, the first issue will be whether the child's life is really on the line and, even if it is, whether the proposed treatment is the only alternative.

As illustrated by the Alberta case of *Re D.*,⁶⁵ the issue is sometimes clear-cut. A full-term baby developed an extremely serious infection, requiring intensive therapy, including transfusions. In a review after the fact, there could be no denying the gravity of the illness or the lack of any real alternative. Arguments thus were strictly regarding the rights of the parents. The Court held that the right of the child to health overrode any rights of the parents. It noted an earlier Supreme Court discussion of freedom of religion⁶⁶ that held that the freedom includes the right to profess and disseminate one's faith but not to avoid compliance with provincial laws. On that same note, in a post-*Charter* case, the Supreme Court held that the *Charter* does not preclude the legislature from imposing any burdens on the practice of religion.⁶⁷ Thus, put simply, courts will not allow a child to die because of a parent's religious objection to treatment.

Nevertheless, the parents will frequently argue that the situation is not as critical as claimed. This brings out conflicts in medical opinion.

62 *Re C.P.L.*, *supra*, note 18.

63 Gyles, *supra*, note 18.

64 *Supra*, note 51.

65 *Re D.* (1982), 30 R.F.L. (2d) 277 (Alta. Prov. Ct).

66 *Walter v. A.G. Alta.*, [1969] S.C.R. 383.

67 *Jones v. The Queen* (1986), 31 D.L.R. (4th) 569 (S.C.C.).

Interestingly, the arguments are quite repetitive and the characters familiar. On the one side are usually local experts, always specialists, and usually the leading people in their field in that city. On the other side are individuals who, if specialists, are seldom paediatricians, and more often, have not treated children or newborns in recent years, if at all. They are almost always brought in from elsewhere, often from the U.S.

There are many examples of the difficulty these "experts" have in these cases. In a situation that was medically obvious, a shocky car accident victim was claimed by the plaintiff's experts to not have been in shock and hence not in need of blood.⁶⁸ The judge accepted that, on the contrary, these experts' opinions were "nonsense." In other words, this was more than just a difference of qualified medical opinion. Such testimony came across as either incompetent or devious.

In *Kennett*,⁶⁹ when asked to discuss surgery in haemophiliacs, the expert, an obstetrician, offered his opinion on when surgery could be performed. He claimed the expertise:

I am capable of reading the books and acquiring the knowledge I want on any particular subject...I can read the books about hematology as well as other doctors.⁷⁰

The judge found his comments to be without value.

This same doctor, and others, also claim enough expertise in neonatology to recommend the "hands off" approach to premature newborns. In one case,⁷¹ a baby was born at 26 weeks weighing 400 grams. Put simply, this baby's chances were poor even with full treatment. The family argued that, because no baby this small had survived in that hospital before, the neonatologists there must be doing something wrong. The Court accepted that such a record had more to do with the profound difficulties these babies face than with any harm imposed by treatment. In that case, there was also testimony from a different kind of expert:

Dr. Kluge, *an expert in medical ethics*, testified that the aggressive approach to the treatment of S. being carried out by the neonatal intensive care unit was not, *in his view*, mandatory from an ethical standpoint⁷² [emphasis added].

Only slightly more relevant was the testimony in another Alberta case.⁷³ All of the family's experts were physicians, but two had never

68 *Malette v. Shulman* (1987), 63 O.R. (2d) 243 (H.C.J.).

69 Cited in Gyles, *supra*, note 18.

70 Gyles, *supra*, note 18 at 55.

71 *Re S.E.M.*, *supra*, note 50.

72 *Supra*, note 50 at 371.

73 *Re R.K.* (1987), 79 A.R. 140 (Prov. Ct.).

looked after a newborn, and the third had not done so in ten years. Their suggestions for appropriate management were all rejected in favor of that of a local paediatric haematologist who clearly demonstrated the lack of depth in the other side's knowledge of the issues at hand.

Occasionally in these actions, the playing field is a bit closer to level. In a criminal negligence trial, parents were accused of recklessly taking their critically ill child out of hospital to avoid transfusions.⁷⁴ The child died soon after. Countering the qualified and experienced haematologists for the Crown were several others. One the judge described as an "adventurer" and "not even remotely qualified to give evidence." The other was quite different. He had been quite experienced and well published, but the last occasion of the latter was 1946. There was some question as to the currency of his approach. At any rate, the parents were found to have shown a reckless disregard for their child's life, but were nevertheless acquitted as it was not proven the child would have lived but for being removed from medical care.

Thus, when the evidence gets in that the child's life is, was, or will be, in danger without transfusions, the courts have sided with those most qualified to give an opinion. In fact, even only the "possibility" that blood might be needed could warrant intervention,⁷⁵ although this may be more of an issue in provinces requiring an order for treatment. Finally, it is also clear that a court will not accept treatments only "possibly available" elsewhere.⁷⁶

One cannot leave these cases without alluding to the tenor in which the arguments are made. There can only be a hint of this in reading a judgment. Nevertheless, since Jehovah's Witness families are almost inevitably represented by the same one or two lawyers, certain themes emerge. In the Kennett inquest,⁷⁷ Judge Gyles specially commented on the conduct of holding daily news conferences throughout the hearing, and, worse yet, arranging a clandestine autopsy while the inquest was going on. In the criminal case noted above⁷⁸, the judge described as "warped and biased" the accusation by counsel that the doctors involved had allowed the sick girl to get worse on purpose in order to intimidate the parents. In another case concerning transfusion of an unconscious adult despite a wallet card identifying her as a Jehovah's Witness,⁷⁹ the plaintiff's counsel argued that the doctor had only

74 *Cyrenne, supra*, note 56.

75 *Re S.B.* (1983), 36 R.F.L. (2d) 70 (Ont. Prov. Ct.).

76 *Re C.P.L., supra*, note 18.

77 Cited in Gyles, *supra*, note 18.

78 *Cyrenne, supra*, note 56.

79 *Supra*, note 68.

transfused her because of his animosity and contempt for her faith. It was further claimed he had falsified hospital records. The judge found that there had been a battery, but held that such unnecessary allegations had needlessly prolonged the trial, and so he refused to award costs. In short, while child and family cases are often emotionally charged, here one seems to see similar tension reflected in the conduct of counsel.

B. Non-life-threatening situations

As far as the reported case law goes, there are only a few situations where the need for medical or surgical treatment does not involve an immediate threat to life. In other words, without treatment the disability or illness will continue but without the dire consequences noted above. Again, leaving aside children with cancer or mental handicaps, it can be seen that, unlike the first group above, courts will be less willing to override parental objections. However, this hesitancy can be overcome by bringing out in testimony some threat to the child's life in order to shift the scene to the first group discussed above. For instance, in an American case, a young epileptic was denied seizure medication by his fundamentalist mother. At first hearing,⁸⁰ he was found to be in no danger but later evidence showed that a severe seizure could endanger his life. The evidence was that after the first trial he had had such a seizure, suffered a stroke, and was now permanently paralyzed on one side. The "new evidence" allowed the court to find him in need of protection.⁸¹ Interestingly, at issue was a common proviso in state protection laws such that reliance on spiritual treatment alone could not be the only reason to apprehend. The Supreme Court of Colorado read the section narrowly, finding neglect existed here no matter how it arose.

Oddly, examples in this group are exclusively American. The reason for this is unclear. Perhaps Canadian cases occur but are not litigated. Perhaps physicians and agencies are less likely to force the issue here. At any rate, it may be that because of their more extended constitutional notions of privacy, American courts might handle these cases a little differently. One can only say that at the extreme end, the "life-threatening" cases, their authority is even more settled than here. There is fairly longstanding case law,⁸² and some Supreme Court rulings,⁸³ that clearly sanction state intervention if a refusal to treat endangers a child, and further that such intervention is constitutional.

80 *Re D.L.E.*, (1980) 614 P.2d 873 (Colo. S.C.).

81 *Supra*, note 80.

82 *Wallace v. Labrenz*, (1952) 104 N.E.2d 769 (Ill.).

83 *Jehovah's Witnesses of Washington v. King County Hospital*, (1968) 278 F.Supp.488, *aff'd* 390 U.S. 598.

That said, no matter what the statutory framework or constitutional background, decisions are still the result of the exposition of the facts. Thus an order may be granted if it can be shown that the disability to be treated was depriving the child of some benefit to which they should be entitled. Consider a child who is being kept out of school because of a severe facial disfigurement.⁸⁴ Educational and psychological development were suffering. The condition could be corrected but transfusions would be necessary. Because education was a right, the court ordered the surgery over the religious objections of the parents.

Where the risks are greater, and the results perhaps less clearly beneficial, courts are less likely to intervene. In one case, the amputation of a grossly deformed arm was recommended by the surgeons.⁸⁵ The court did not intervene because of the great risks of such extensive surgery at that time and the parents' objections, which were not religious but only based on fear of a bad result. Treatment was also not found "required" or "necessary" in another case concerning a polio victim who required a spinal fusion to allow ambulation.⁸⁶ The surgery would be accepted but it required transfusions and even then there was some element of risk. More importantly, delay until the child could decide for himself was a possible option. Similarly, in older cases the risks of surgery could be so great the courts would resist forcing the procedure on a child.⁸⁷ But even forty years ago, if the benefits clearly outweighed the risks surgery could be ordered, for example, in a foot operation.⁸⁸

There are other factors that may here tilt the scales. Where the parents' reliance on non-medical healing results in a condition of general neglect, and possibly unnecessary suffering, courts will intervene if the condition is correctable. Thus three children in one family had their tonsils and adenoids ordered removed.⁸⁹ The children were chronically unwell and were at risk of hearing loss. Similarly, another child was found neglected because of a hernia, cavities, and dental fractures, untreated because of mother's religious objections.⁹⁰ It may be relevant that these parents were rejecting all medical care, not just one aspect, such as transfusions.

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- 84 *Re Sampson*, (1972) 328 N.Y.S.2d 686.
 85 *Re Hudson*, (1942) 126 P.2d 765 (Wash.).
 86 *Re Green*, (1972) 292 A.2d 387 (Pa.).
 87 *Re Tuttendario*, (1911) 21 P. Dist. 561.
 88 *Re Rotkowitz*, (1941) 25 N.Y.S. 624.
 89 *Re Karwath*, (1972) 199 N.W.2d 147 (Iowa).
 90 *Re Gregory S.*, (1976) 380 N.Y.S.2d 620.

A parent is also allowed to express dissatisfaction with a treatment offered.⁹¹ A hyperactive child was taken out of a treatment centre by his mother who had various objections to the approach used there. As the child was placed in a different centre, the court could find no neglect.

Of greater difficulty was a 14-year-old with a cleft lip and palate, conditions usually corrected in infancy.⁹² Both his father and he professed a belief in natural healing. The court did not order surgery for two reasons. The already existing delay may preclude as good a result as would otherwise occur, and, critically, post-operative speech therapy would require co-operation, and given the family's attitude, that would be unlikely.

Thus on balance, we have the therapeutic benefits and risks, the true nature of the objection, and other factors such as the need for co-operation. With the possible exception of this last case, it is submitted that the courts decide these cases as reasonable parents would. Where the issue is fairly clear, they have so found. Where a reasonable parent might hesitate, they have also hesitated. Thus the advocate on one side must emphasize the benefits, including the non-medical ones. Opposing counsel must highlight the risks and, if possible, introduce enough other issues to make the decision as unclear as possible.

C. Children with cancer

Among the most difficult cases in paediatrics are children with malignancies. This difficulty is reflected in society and in child protection cases should the issue come to a court. But the problems arise from different perspectives for the different sectors. While the lay public may still see these children as, by definition, terminal, physicians will be aware of developments that have, in many cases, produced outright cures. For example, in certain types of leukaemia, more children than not can expect such longstanding remissions that relapses are virtually impossible. As experience increases and time goes on, the certainty of these cures becomes more definite.

Even accepting the possibility of a cure, society still has trouble with the toxicity of treatment. (The very term "chemotherapy" has a horrific connotation, although it equally applies to antibiotics and cold medicines.) One could argue that a complete cure would warrant considerable suffering if the alternative is death. But more to the point, with some exceptions, the side effects are temporary and completely resolve. Furthermore physicians are also well aware that the alterna-

91 *Re B.*, (1973) 497 S.W.2d 831 (Mon. App.).

92 *Re Seiferth*, (1955) 127 N.E.2d 820 (N.Y.).

tive to treatment is not a gentle, easy passage into the night but often a prolonged course of dying,⁹³ often with intractable pain. In short, both physicians and the public come to the issue with some preconceptions. In addition there remains an overwhelming attractiveness for an easy answer, an easy cure. Both well-meaning and less well-meaning physicians, and others, will offer one, and, in desperation, there will always be some who will accept such an alternative.

When these cases do come to court, the issues of life and death, risks and benefits, are again played out but colored by the above preconceptions and prognostic difficulties. When the issue appears clear-cut, the court will authorize treatment. Such was done in an older case⁹⁴ where removal of a cancerous eye had an excellent chance of success. The parents had objected because they wanted the baby the way God had made it. Near the same end of the spectrum is a 1979 Massachusetts case of a two-year-old with acute lymphocytic leukemia.⁹⁵ Whatever chance, and it was a good one, the child had would only result from chemotherapy. The parents wanted to use laetrile and vitamins. Two of their experts were not physicians, the others were not licensed in Massachusetts, and none had any experience with leukemia. Further, there was evidence that laetrile had risks of its own. The welfare of the child, the court found, warranted ordering the proper treatment. As it was, the parents fled with the child to Mexico where he died at a laetrile clinic.

Unlike the emergency transfusion cases, any court ordered therapy for cancer treatment might be impossible to give without a long term apprehension. Thus courts have been willing to accept alternatives proposed by the parents. Hence, in an eight-year-old with Hodgkin's disease, this was done.⁹⁶ There was less clear evidence about prognosis, and the alternative was being offered by a licensed physician. In addition, the physician did not rule out chemotherapy if the condition warranted. In other words, the parents were accepting some locally available and apparently qualified medical care.

It is now useful to confront two difficult Canadian cases. The first concerns Catherine Couture-Jacquet.⁹⁷ At about age two, she had surgery for a sacrococcygeal teratoma, an uncommon tumor of the pelvis. Three courses of chemotherapy, first with consent and then by

93 "He remained conscious until an hour before he drowned after three days of pulmonary edema" (Dane R. Boggs, "Jehovah's Witnesses with Leukemia" (1985) 20 *Hospital Practice* 92 at 95).

94 *Re Vasko*, (1933) 263 N.Y.S. 552.

95 *Re Custody of a Minor*, (1979) 393 N.E.2d 836 (Mass.).

96 *Re Hofbauer*, (1979) 419 N.Y.S. 2d 936.

97 *Couture-Jacquet v. Montreal Children's Hospital*, [1986] R.J.Q. 1221 (C.A.).

court order, were given, and the child went into remission for several months. She eventually relapsed and consent to treatment was again refused, and a court order sought. The case reached the Quebec Court of Appeal. Catherine's mother and grandmother, who had actual custody, wanted her to die "in peace." Her physicians felt she should be given a chance, even if it was only a small one, perhaps ten to twenty per cent.

The Court refused to authorize treatment. On the face of it, they thus denied her the ten to twenty per cent chance of surviving. But the issue is more complicated than that. Firstly, up to a point, treatments had been consented to. It was only after significant, non-reversible side effects began to appear that the mother objected. Further therapy would likely worsen those toxicities, particularly kidney function, such that permanent dialysis or a transplant would be necessary. On the other side, the success rate was likely less than the ten to twenty per cent claimed. That result was extrapolated from a small number of cases, some with a different type of tumor. There were, in fact, no reliable statistics on cure rates. Put simply the choice in the case was anything but straight-forward.

It is further submitted that perhaps the special Quebec statutory provisions finally tilted the court to withholding treatment. Although the *Civil Code* recognizes the child's interests as the determining factor,⁹⁸ the statutory embodiment of the *parens patriae* power authorizes court ordered treatment:

... where the refusal by the person having parental authority is *not justified* in the child's best interest...⁹⁹ [emphasis added].

Thus, Monet J.A. describes the power of the Superior Court:

La Cour Supérieure, tout en conservant son rôle traditionnel de défenseur et de protecteur ultime des droits de l'enfant, ne doit pas s'attribuer le droit de prendre ou d'imposer ce genre de décision, en l'absence de *refus injustifié* du titulaire de l'autorité parentale¹⁰⁰ [emphasis added].

It seems, therefore, that the Court did not really have to decide which of two alternatives was better but only whether the one chosen was "unjustified." In the close cases, it is submitted this is a real distinction. Withholding treatment could be justified without necessarily finding that to be in the child's best interests.

98 Art. 30, C.C.L.C.

99 *Public Health Protection Act*, R.S.Q. 1977, c. P-35, s. 42.

100 *Supra*, note 97 at 1236.

Another difficult case is that of *Lisa Dorothy K.*¹⁰¹ This twelve-year-old developed acute myeloid leukemia, which has a poor but not hopeless prognosis. Her family were Jehovah's Witnesses and objected to any chemotherapy that might necessitate transfusions. In fact, they objected to such therapy in general, even without transfusions. They had travelled extensively, even to Mexico, seeking a treatment acceptable to them. A significant issue here is the value of the child's opinion, the notion of the mature minor. That area will be discussed later. At this point it is only necessary to look at the "disease" issues.

First of all, unlike *Couture-Jacquet*, Lisa had not yet had any real treatment. It was the anticipation of problems rather than actual experience with them which was the issue. Also unlike the Quebec case, the disease was common enough to give more reliable cure rates, here claimed to be thirty per cent. On the other side, a local general practitioner, without any experience in childhood leukemia, claimed chemotherapy only had a ten per cent success rate but offered no figures at all for her proposed multi-vitamin regimen. The judge noted the chemotherapy's side effects of pain and hair loss, mused that other effects may not be known, and in the end described the proposed chemotherapy as "extremely toxic," an "ordeal". On the other hand, the parents wanted "rigorous mega-vitamin therapy" that could be given with "dignity... surrounded by family." Although the judge seemed to be making an informed decision, it was in fact a choice between no therapy and a modest, but difficult, chance of survival. Clearly the picture had been coloured. One factor, as noted, was Lisa's own wishes. Another was that somehow one transfusion had already taken place. The judge found this violated her *Charter* rights. Without going into whether it did or did not, it seems irrelevant as to the fundamental issue, whether she is in need of treatment now. If she had suffered a wrong, the remedy should not be a change of finding as to whether she is in need. Suffice to say that issue affected the judge's reaction to the haematologists' approach. Granted this was a summary decision, given orally, and perhaps there was a case for withholding treatment, but it does seem at odds with the general tenor of cases elsewhere, at least insofar as how the medical evidence was accepted.

Of interesting contrast is the case of Pamela Hamilton,¹⁰² another twelve-year-old, this time with a bone tumor and this time in Tennessee. She was given a twenty-five per cent chance of survival with treatment. The alternative of no treatment would result in "certain painful death," with the pain becoming "more excruciating." Now this

101 *Re L.D.K.* (1985), 48 R.F.L. (2d) 164 (Ont. Prov. Ct).

102 *Re Hamilton*, (1983) 657 S.W.2d 425 (Tenn. App.).

is an appellate decision without the parties giving evidence before the court. No mention is made of the child's wishes. The parents belong to a sect that rejects all medication. The judges do make note of these comments made by the father:

Well, if they're going to give you something to make you sick and your hair come out, it must not be too good for you. If they can't guarantee it to heal you, why do it, because if a doctor were to tell me he had a medicine that would heal me I'd go right there in just a minute, but there ain't none.¹⁰³

The Court describes his approach as "pragmatic if not enlightened."

There are some interesting differences with Lisa K.'s case. No "alternative" was being offered here. Lisa and her family are found more "enlightened." Nevertheless, no mention is made of Lisa's expected demise. Medically, there is no reason to think her death will be any less unpleasant than Pamela's. The two cases do illustrate how similar fact situations can come across quite differently in court. These differences have more influence on the eventual result than any underlying bioethical themes.

Practically then, the issues in these cancer cases always seem a little less clear cut. Reliable predictive statistics are important, but rightly or wrongly they can be discredited. All concerned want an easy solution. One will usually be offered. To counter, the real gravity of drug toxicities has to be clear, and the real result of non-treatment has to be presented.

D. Treatment choices in handicapped children

The issue of when and when not to treat the handicapped child is an ethical lightning rod. It focuses our engrained attitudes on the value of life, our urge for privacy, our tendency to intervene in other's problems, and perhaps more than in other cases, our empathy for all concerned. Obviously, if there were an easy answer, there would be no need to discuss this here or anywhere. All one can do is to try to analyze the various doctrines that have been applied, but it is again suggested that the case-to-case variations in the facts are the real determinate of the ultimate result.

Perhaps the best examples of this are a couple of cases not involving children, but retarded adults. These cases were widely mooted as reflecting fundamental differences in our approach to retarded adults. Their results were considered to be in dramatic conflict, but the truth is that, on their facts, the decisions are quite compatible. First, there is the

103 *Supra*, note 102 at 428.

Supreme Court of Canada case of *Eve*.¹⁰⁴ Eve, twenty-four at the time, was being considered for sterilization. Her mother, Mrs. E., feared Eve would become pregnant, was concerned about the effects of pregnancy and birth on her daughter, and was also concerned that she, at the age of sixty, would become responsible for any child resulting. The Court saw some benefit to Eve in avoiding the trauma of birth, but noted that her mother would also benefit. However, they could find no evidence that "failure to perform the operation would have any detrimental effect on Eve's physical or mental health." The Court re-emphasized that the interests to consider are exclusively Eve's. Hence, on the facts before them the issue failed this most basic test. Unfortunately, the Court went on to say that non-therapeutic sterilization could never be offered an incompetent person. That dicta was severely criticized in the English case that came a few months later.

In *Re B.*,¹⁰⁵ the House of Lords was considering the case of a girl who was seventeen and severely retarded. Without sterilization, her freedom would have to be strictly curtailed. And a pregnancy would have created real problems. Her obesity and retardation would delay diagnosis until it would be too late to abort. She would thus be obliged to go to term and would likely require a Caesarian section. Such an incision should be avoided in a person thus retarded. In other words, unlike Eve, there were clear detriments that B. would suffer if she got pregnant and, in fact, was already clearly suffering by virtue of her decreased independence. Sterilization was allowed.

Hence, the facts as they came out yielded very different answers as to what was in these individuals' best interests. Both courts accepted this as the only issue to address, because neither woman could or would ever be able to consent to any procedure on her own. Similar standards were applied in another English retarded woman who was fourteen weeks pregnant.¹⁰⁶ Her best interests, it was found, clearly allowed an abortion and sterilization.

Among the issues that come up in treatment discussions for the mentally incompetent and that is thus mentioned in similar paediatric cases, is the right of the patient to refuse treatment. That is, the patient is allowed to "decide" to go untreated or to have treatment withdrawn. In these cases, such a decision would have to be made by another, by proxy. American decisions dealing with ceasing life-support in incompetent adults have stressed that the individual's rights to privacy, and thus to refuse treatment, cannot be denied simply because they are in-

104 *Re Eve, supra*, note 26.

105 *Re B.*, [1987] 2 All E.R. 206 (H.L.).

106 *T. v. T.*, [1988] 1 All E.R. 613 (Fam.D.).

competent.¹⁰⁷ If a competent adult can refuse new or further treatment, why can't an incompetent? In these so-called "right-to-die" cases, refusing treatment by proxy may be the only way to get out of futile or unnecessary treatment.

However, this "right" not to be treated should have little application to the children's cases discussed here for two reasons. Firstly, the issue only tends to be brought forward when the result sought may well be contrary to the ruling legal standard, the best interests of the child. For many reasons, it may be impossible to say that a child's best interests lay in death. If nontreatment and eventual death is the result sought, it is necessary to shift the argument away from the "best interests" approach. There may be situations where nontreatment is in the child's best interests. However, if it is not, and we allow the intrusion of the notion that the child, by proxy, can choose to avoid treatment, then we run the risk of blurring the issue to the point that the best interests approach loses its dominance.

The other difficulty with comparing a now incompetent adult with a child is that the child has never had the right which the adults almost lost before cases like *Quinlan*. An infant has never had the absolute right to refuse treatment. A three-year-old may resist a procedure or operation, but, if his parents consent, his refusal is meaningless. It is ludicrous to argue that a retarded child somehow has such a right to refuse. Any child's wishes, if he has any, always yield to those of his parents or, in some situations, to that of society. Decisions are made *for* the child in his best interests, not *by* him, whether he is handicapped or not.

The above arguments were made in the ethical criticism that followed the Stephen Dawson case.¹⁰⁸ But this case has much less to do with notions such as these than with the way the facts played out before the court. This is well illustrated here because of the unusual situation that the appeal of the case was a trial *de novo*. We can compare the facts as they came before each court and note how the result was influenced.

Stephen Dawson was a severely retarded boy with hydrocephalus, a collection of fluid in the brain. This fluid drains by means of a shunt, a tube passing into the abdomen. If the tube becomes blocked, the shunt then needs to be revised to relieve the buildup of pressure in the brain. Such a revision is fairly straightforward, and some hydrocephalics require several such procedures. It was at the point when Stephen

107 *Re Quinlan*, (1976) 355 A.2d 647 (N.J.); *Re Colyer*, (1983) 660 P.2d 738 (Wash.).

108 *Supra*, note 5.

needed this procedure that his parents withheld consent and that child care officials sought custody.

In Provincial Court,¹⁰⁹ it was noted that Stephen had been institutionalized or fostered out most of his life, because his parents could not manage him. There was testimony that they had maintained contact, and had, all along, planned to withhold surgery if the situation arose. They had also resisted Stephen becoming a ward despite being "harassed and vilified" by social workers for not doing so. Medical testimony came out as to how little progress he had made, although some of his caretakers thought there had been some improvement. When the issue of surgery arose, it was considered the right time to let him die "in peace and dignity." After he was taken home to prevent the surgery, authorities came across as rather heavy-handed. At one time, when a social worker came by to assess Stephen's condition, police broke the door down. When he was eventually apprehended, the police did it while the social workers waited outside. The judge came to the conclusion that the shunt was a "life support system" that Stephen had the right to have discontinued, as was done in the *Quinlan* and *Colyer* cases.

When the case was heard again a few days later in the British Columbia Supreme Court,¹¹⁰ the picture came out somewhat differently. First, the relative lack of involvement, to the point of almost rejection, by the parents came out. It was clear his teachers were more familiar with him than his parents. Thus, evidence came out of a "happy child," responsive to his environment, with more potential than originally thought. Medical testimony suggested a peaceful death was not the alternative to surgery. He would likely have increasing pain, may not die at all, and would more than likely deteriorate from any progress he had made. To find otherwise than that surgery was necessary, would not be in his best interests. Not allowing the appeal would place a lesser value on Stephen's life than that of a normal child.

Hence the two hearings yielded different results due in large measure, it is submitted, to the different scenes played out before the court. To be sure, a judge when reporting the facts will see them in the light of the eventual ruling. But at least as they are reported, the decisions are, at some level, consistent with their facts. We cannot really know the true scenario. Were the parents truly caring or did they just want to be rid of Stephen? How objective were those looking after him? Were the social workers really acting like stormtroopers? It may be that such

109 *Re S.D.*, [1983] 3 W.W.R. 597 (B.C. Prov. Ct.).

110 *Supra*, note 25.

issues are largely irrelevant, and that Stephen was entitled to a certain result no matter what was going on around him. Suffice to say that the result he got was largely a function of the way the evidence was led during the second hearing.

Recent caselaw has thus made the quality of a child's life a real non-issue in a court's treatment decisions. Keeping in mind the earlier comments on Down's syndrome it seems almost impossible for a court to allow surgery to be withheld. Hence, a two-year-old Quebec girl with Down's syndrome had heart surgery over her parents' objections.¹¹¹ To deny her treatment would be to discriminate against her because of her handicap. Here again she had been fostered since birth and the parents' "interest" in her welfare tends to be thus attenuated. Similarly, in *Re B.*,¹¹² an English newborn with Down's syndrome had her intestinal blockage repaired, because she clearly had the same right to life as a "normal" child. Her best interests lay in surgery.

Occasionally, the courts do get it wrong. In a much criticized case,¹¹³ the California Court of Appeal refused to allow heart surgery on a ten-year-old with Down's syndrome. Phillip, who had been institutionalized his whole life, needed surgery to stop a progressive condition which untreated would result in his demise in twenty years. Because he was a Down's, the surgery carried an increased risk. Claiming that it would be unfair to expose him to that risk, the court said there would have to be "clear and convincing evidence" that intervention was necessary.

A somewhat different picture came out a few years later. A couple who had become involved with him to the point of being his de facto parents, sought appointment as his guardians.¹¹⁴ In this discussion, we find Phillip to have an I.Q. of 57 and thus having a good potential to be employable and possibly even independent. Testimony also revealed his skills in speech and caring for himself. His parents had actually rejected him from birth. They had little contact with him and, in fact, thought it better that an institutionalized child not form emotional attachments. They only became more involved when the other couple appeared to be taking over. Even at that, they had reneged on promises to seek further opinions on Phillip's heart problems. They were worried that he would survive them. The Court granted the order for guardianship, and with the hindsight also seen in *D.L.E.*,¹¹⁵ noted that

111 *Goyette, supra*, note 24.

112 *Re B.*, *supra*, note 24.

113 *Re Phillips B.*, (1979) 156 Cal. Rptr. 48 (App.); George J. Annas, "Denying the Rights of the Retarded: The Phillip Becker Case," (1979) 9 *Hastings Center Rep.* 18.

114 *Guardianship of Phillip B.*, (1983) 188 Cal. Rptr. 781 (App.).

115 *Re D.L.E.*, *supra*, note 80.

the heart problem had progressed to the point of apparently being no longer correctable by surgery. Although Phillip did in fact eventually have the surgery, it seems clear that a more complete picture of all the facts coming before the first hearing might have provided a more positive result sooner.

Before leaving this group of cases, it should be noted that in some situations the subtleties of the medical decisions may be confused with issues regarding the quality of life. A good example is a meningocele or spina bifida wherein a part of the spinal cord is exposed and there is associated paralysis. In the worst cases, with a large defect, high in the back, death is inevitable no matter what is done. The smaller ones, lower in the back, can be associated with good function but, until the defect grows in, there is a risk of infection. Closing it surgically stops that problem but may, to some extent, aggravate the paralysis. With larger defects, the greater risk of infection may be accepted in hopes of ensuring the maximum amount of function in the long run. Hence one can have perfectly compatible decisions in favour of non-treatment of Baby Jane Doe¹¹⁶ but ordering treatment in another case best handled by surgery.¹¹⁷ Both results could be in a child's best interests.

E. Mature minors

When these cases involve adolescents, the court may be interested in what the child has to say. While child protection legislation directs the court's attention to the wishes of the child,¹¹⁸ it is unclear how much weight that should be given. Part of the problem results from a statutory muddle with some provinces not recognizing the capacity to consent until majority, another as young as fourteen,¹¹⁹ and another at the time when the minor is capable of "understanding the nature and consequences of medical treatment."¹²⁰ In addition child protection legislation may cover children up to the age of majority or only until sixteen. These diverse statutory approaches can leave it a little inconsistent as to at what age a court has authority, statutory or otherwise, to sustain or overrule a child's or parent's refusal of treatment.

We can accept for the moment that minors, whether emancipated (that is, independent of their parents) or mature (capable of making the decision) can consent to beneficial treatment. But when do they have the right to refuse? We would likely accept such a refusal if a parent

116 *Supra*, note 20.

117 *Ex parte Cicero*, (1979) 421 N.Y.S 965.

118 *Supra*, note 1, s. 2(f).

119 *Supra*, note 99, s. 42.

120 *Medical Consent of Minors Act*, S.N.B., c. M-6.1.

wanted cosmetic surgery but the minor did not. In contrast, we would likely reject a minor's refusal of an emergency appendectomy if the parents consented.¹²¹ Although the case law seems limited to abortions,¹²² it also seems likely that a minor could consent to treatment over their parents' objections. The only mechanism that is compatible with all these scenarios is that we allow the child and the parents to make these decisions as long as that decision is in the child's best interests. As soon as it appears it may not be, then society, through the courts, may consider intervening.

The issue is highlighted by the case of Lisa Dorothy K.,¹²³ discussed above. There Judge Main accepted her refusal of chemotherapy because of her religious objections and "because she does not want to experience the pain and anguish associated with the treatment process."¹²⁴ Lisa was willing to accept the consequences rather than suffering the side effects of treatment, particularly the pain and hair loss. The judge clearly considered Lisa's own views important:

L. is a beautiful, extremely intelligent, articulate, courteous, sensitive and, most importantly, a courageous person. She has wisdom and maturity well beyond her years....¹²⁵

The judge found Lisa to be mature enough to offer an opinion of value. The question is can that maturity really be assessed in court and could a court, to be consistent, also accept that refusal by a twelve-year-old if the parents had instead consented.

It is first important to not look at this issue in isolation. Other areas of the law make it clear that Lisa, at age twelve, could not marry, could not sign a binding contract, and could not legally drive a car. Yet a court may find that, at that age, she is capable of making life or death decisions for herself.

Are children of that age capable of understanding the significance of treatment options? Studies have shown the matter far from settled. We know that as children grow older they go through levels of understanding that range from seeing illness as contamination, to punishment, to the result of some personal weakness. In several studies a reasonably mature level of understanding was not reached until age twelve or thirteen and, even at that, only in about a third of the chil-

121 Angela R. Holder, "Minors' Rights to Consent to Medical Care" (1987) 257 J. Am. Med. Assoc. 3400.

122 *J.S.C. v. Wren* (1986), 49 Alta. L.R. (2d) 289 (C.A.).

123 *Supra*, note 101.

124 *Supra*, note 101 at 168.

125 *Supra*, note 101 at 171.

dren at that age group.¹²⁶ In other words, considering a child "mature" at that age is really cutting it fine, with little margin for error. Furthermore, the ability of the child to understand what was going on was well correlated with the child's previous experience with the problem. Children with chronic illnesses, who had experienced hospitalization, had a better concept of their illnesses and treatment than children in hospital for the first time.¹²⁷ In addition, there is evidence that the factors which influence a supposedly mature minor may not be the ones we would want. At any age, children and adolescents are preoccupied with the present and less concerned about future consequences. There is a real difficulty in considering the "long view." In addition, whether it appears so or not, adolescents are always concerned about the effect of treatment on their appearance.¹²⁸ Hence it is possible, and often probable, that an adolescent may come to a decision based on the short term effects of treatment rather than its long term benefits.

Another factor is that even if the cognitive ability is there, the voluntariness of any consent may be questioned. This does not mean there is any element of coercion or duress. Rather it concerns the influence of parents on their children. The negativeness and rebellion of the adolescent years is well known. However, studies have shown that under the age of fifteen, it is in fact unlikely these minors will assert themselves against their parents in treatment decisions.¹²⁹ In other words, even if they will feel confident in their choices of music or clothes, when confronted with a frightening situation, unlike any dealt with before, they will look first to parents for the answer. What this means is that even if they themselves would come to a certain conclusion independent of their parents, for some period of time after they are thus capable, they would still yield to the wishes of their parents.

Hence we have some evidence that would make us skeptical of a twelve-year-old, in hospital for the first time, being capable of going against her parents' wishes in order to make a decision favouring a long term result over a short term one. Compare Lisa to a very different scenario: a sixteen-year-old with chronic kidney disease, who cannot be transplanted, faces dialysis for the rest of her life.¹³⁰ She is well

126 Ellen C. Perrin, "There's a Demon in Your Belly: Children's Understanding of Illness" (1981) 67 *Pediatrics* 841.

127 Arlene B. Brewster, "Chronically Ill Hospitalized Children's Concepts of Their Illness" (1982) 69 *Pediatrics* 355.

128 Sanford L. Leikin, "Minors' Assent or Dissent to Medical Treatment" (1983) 102 *J. of Pediatrics* 169.

129 *Supra*, note 128.

130 John E. Schowalter, "The Adolescent Patient's Decision to Die" (1973) 51 *Pediatrics* 97.

aware of what she is in for, and, with her parents and physicians, refuses further dialysis. There are certainly some situations where the minor's choice may warrant respect. How can one find the line between these?

It could be argued that even if the odds are against someone like Lisa really being able to make such decisions, a judge could assess her maturity and decide what weight to give to her wishes. Studies suggest this may be difficult. Much like a law student being pressed by a "Socratic" professor, adolescents consistently demonstrate less real understanding than is initially apparent.¹³¹ On first enquiry they may seem to understand the issues, but, in fact, they really do not grasp the problem. A court should be careful about first impressions. Another study looked specifically at judges' ability to assess maturity.¹³² Some American states allow a minor to consent to an abortion if she is judged mature enough at a hearing. A series of 477 of such hearings were looked at, covering girls from age thirteen to seventeen. Using specific guidelines, the judges found nine of these minors too immature to consent. The interesting aspect is that the lawyers involved, who had supposedly greater exposure to their clients, found eleven of them immature but there was only concordance with the judges' opinions on one case. This seems to call into question the ability to develop useful guidelines, or the ability of judges to make accurately such rulings. As an aside, it should be noted that those found immature were still granted an abortion as the judges found it in the girls' best interests.

This study also highlights a potential pitfall in this area. It is tempting to extend doctrine regarding a minor's right to consent to an abortion to other medical decisions. Most of the above minors in the maturity hearings were found mature. Possibly such a finding was just another way of finding the abortion to be in their best interests. It is more likely that only the more mature minors were appearing before them. It is not that getting pregnant makes them mature, but the fact that they are seeking an abortion without their parents' consent or even knowledge. The ones who are not "mature" would likely not go that route. In other words, the cases are almost pre-selected. Thus when a court recognizes a girl's right to an abortion,¹³³ it is also recognizing her independence from her parents, as the House of Lords noted:

131 *Supra*, note 126.

132 Susanne Yates, "Judging Maturity in the Courts: The Massachusetts Consent Statute" (1988) 78 *Am. J. of Public Health* 646.

133 *Supra*, note 122.

Having regard to the reality that a child became increasingly independent as it grew older and that parental authority dwindled correspondingly, the law did not recognize any rule of absolute parental authority until a fixed age. Instead, parental rights were recognized by the law only as long as they were needed for the protection of the child and such rights yielded to the child's right to make his own decisions when he reached a sufficient understanding and intelligence to be capable of making up his own mind.¹³⁴

There are two other points worth a mention. Courts may avoid assessing the maturity of the child in question. In *Hamilton*¹³⁵, it is not even mentioned. In an Ontario case,¹³⁶ a seventeen-year-old car accident victim, although refusing transfusions himself, was found not competent because of his injuries. His divorced parents also refused, so custody was awarded to his grandmother who consented. Also, an Illinois girl of the same age, needing chemotherapy, was allowed to refuse as she was so close to the age of majority, that she could do so on her own in a few months.¹³⁷ The other consideration is the need for co-operation by the adolescent. Thus Lisa said she would fight any therapy that was ordered. In the case of the boy with the cleft lip,¹³⁸ it was found that his co-operation was essential to the success of the procedure. It would seem then that where long term "acquiescence" is necessary, the minor's opinion may carry more weight. On the other hand, that opinion and lack of co-operation may be given little weight if the minor is rejecting essential treatment to which his parents have consented.

To conclude this issue, courts should be reluctant to judge a minor mature enough to decide against their own best interests. They may well appear competent when they are not, their decisions may be more influenced by their parents than is immediately obvious, and there is some question as to whether courts are able to assess maturity consistently or accurately. Furthermore, finding capacity for these decisions is inconsistent with other areas of the law concerning that issue. This entire question deserves a very cautious approach.

V. CONCLUSION

WHERE A COURT MUST MAKE OR REVIEW A DECISION authorizing medical treatment of a child, advertently or otherwise it bases its finding on the best interests of the child. It is submitted that even when the statu-

134 *Gillick v. West Norfolk Area Health Authority*, [1985] 3 All E.R. 402 (H.L.)

135 *Supra*, note 102.

136 *Supra*, note 51.

137 *Re E.G.*, (1987) 515 N.E.2d 286 (Ill.App.).

138 *Supra*, note 92.

tory test is the question of the need for protection, that finding will be the result of the court's assessment of the facts relevant to the child's best interests. This requires a full exposure of the relevant medical and other evidence. When the child's life is at stake the court should not hesitate to intervene. On the other hand, where the benefit appears to accrue to a parent or other party, the court should approach with skepticism. Caution should also rule where alternative mechanisms to the best interests test are advanced. Such alternatives include any which may allow a child, by proxy or as a mature minor, to refuse treatment against their own best interests.