INSTITUTE OF LAW RESEARCH AND REFORM
THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA

Report No. 19

CONSENT OF MINORS TO HEALTH CARE

DECEMBER 1975

TABLE OF CONTENTS

The Institute of Law Research and Reform was established on January 1, 1968, by the Government of Alberta, the University of Alberta and the Law Society of Alberta for the purposes, among others, of conducting legal research and recommending reforms in the law. Its office is at 402 Law Centre, University of Alberta, Edmonton, Alberta, T6G 2H5. Its telephone number is (403)432-5291.

The members of its Board of Directors are Judge W. A. Stevenson (Chairman), W. F. Bowker, Q.C., R. P. Fraser, Q.C., W. Henkel, Q.C., Dr. M. Horowitz, W. H. Hurlburt, Q.C., Ellen Jacobs and F. A. Laux. Dr. Horowitz is the Vice-President (Academic) of the University of Alberta and is ex officio a member of the Institute's Board but takes no part in its recommendations.

Its legal staff consists of W. H. Hurlburt, Director; Margaret A. Shone, Counsel; and Vijay K. Bhardwaj, Rajiv Malhotra, William R. Pepler and Gerry Van der Ven, Legal Research Officers.

CONSENT OF MINORS TO HEALTH CARE

I
INTRODUCTION

This report is made pursuant to the request of the former Minister of Health and Social Development, transmitted to us through the former Attorney General on 2nd January, 1975. Previously, on 22nd October, 1974 the College of Physicians and Surgeons had written us to ask our support for legislation prescribing the age at which a minor might give his own consent to medical treatment. Even earlier, on 31 May 1973 a group called The Family Planning Conference in Alberta had sent to us a resolution asking us "to investigate the legal pressures limiting the prescription of contraceptives for girls under eighteen without parental consent." We had a student gather material on this subject. The result of his research has been published in Gilborn, Legal Problems of Contraceptives (1974) XII Alta. Law Rev. 359.

The urgency of other projects prevented us from taking on this subject as a formal project prior to the current year. After receiving the formal request from the Attorney General, one of our legal research officers Mrs. G. van der Ven prepared an exhaustive background paper on the whole subject of consent of minors to medical treatment. Copies of this background paper are available and will be provided on request.

In July we prepared a memorandum setting out the law and various alternatives for reform. We sent the

memorandum to the College of Physicians and Surgeons, the Alberta Medical Association, the Alberta Society of Obstetricians and Gynecologists, the Alberta Hospital Services Commission, the Medical Officers of Health in Edmonton and Calgary, Edmonton Social Services, the Calgary Social Service Department, and the Provincial Family Planning Coordinating Committee.

We have now heard from nearly all those to whom we sent the memorandum. Time did not permit the wide circulation of a working paper, because the government has made it clear that it wants our report immediately.

II
THE PRESENT LAW

The general rule is that medical treatment can be given only with the consent of the patient. In medical examinations and surgery, the physician not only touches the patient, but does so in ways that would be a battery (usually called "assault") in the absence of consent. An adult can give his own consent. In the case of those who are mentally incompetent, the consent is normally given by the guardian. We are not concerned with that problem here.

Until recently the age of majority was twenty-one both in Alberta and elsewhere. In 1971, Alberta followed the recent trend to reduce the age of majority (Age of Majority Act 1971 Chapter 1). In this province the reduction was to eighteen years of age, as in Manitoba, Ontario and Quebec. In British Columbia, Saskatchewan and Nova Scotia the reduction was to nineteen years.

There is a wide-spread impression that a person can never give a valid consent to medical treatment until he has

reached the age of majority. At one time this view prevailed in the United States, but even there exceptions are admitted. In England and Canada there never was a rigid rule that the consent of parent or guardian is always necessary to medical treatment of a minor. Lord Nathan in his text on Medical Negligence (1957) at 171-177 says that a minor who is capable of appreciating fully the nature and consequences of a particular operation or a particular treatment can given an effective consent thereto. Two Ontario cases are to the same effect: Booth v. Toronto General Hospital (1910), 17 O.W.R. 118 and Johnston v. Wellesley Hospital (1970), 17 D.L.R. (3d) 139. A useful discussion is found in Wadlington, Minors and Health Care: The Age of Consent (1973), 11 Osgoode Hall L.J. 115, and in Skegg, Consent to Medical Procedures on Minors (1973), 36 Modern Law Review 370.

With the reduction in the age of majority to eighteen there can no longer be any argument about those in the eighteen-twenty age bracket. The oldest minor is now seventeen. Is it possible for a seventeen-year old or a sixteen-year old or even one who is younger ever to give his valid consent? We think that there are cases where a seventeen year old, particularly if he is "emancipated" can give a valid consent, but as one moves to lower ages, sixteen, fifteen and so on, the uncertainty increases. As a consequence a physician dealing with a minor is left in doubt as to when the patient can give a binding consent. We think that legislation is required to specify definitely the circumstances in which a minor can give his own consent.

It is perhaps necessary to emphasize that a physician in treating a minor could possibly incur criminal liability as well as civil. Criminal liability has reference to an offense under the criminal law, whereas civil liability

has reference to an action for damages. Our recommendations have nothing to do with the criminal law, which is for Parliament, not the provinces. Our recommendations have to do with the civil law--in this case the right of the minor to give his own consent and the corresponding right of the physician to treat the minor, without exposing the physician to an action for damages. We have of course kept in mind the existing criminal law in making our recommendations.

III

RECENT LEGISLATION IN OTHER JURISDICTIONS

Before putting forward the details of our recommendations, we shall mention recent legislation or proposals elsewhere. England's Family Law Reform Act, 1969, in reducing the age of majority to eighteen, provides in section 8 (set out in Appendix A-1) that persons sixteen years and over can give their own consent. Subsection (3) says that "nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted." The scope of subsection (3) is not clear. In introducing the Bill the Attorney General stated that it covers consent by patients under sixteen years of age where they are mature enough to give their own consent. Others have suggested that it contemplates consent by a parent for a patient age sixteen or seventeen who has refused consent, or whose consent the physician has not sought. It has even been suggested that subsection (3) covers emergencies. We doubt this, for the subsection speaks of consent, not of absence of consent. In any case we doubt the wisdom of this provision because its effect is so uncertain.

New South Wales enacted the Minors (Property and Contracts) Act, 1970, No. 60. Section 49 of that act (set out

in Appendix A-2) provides that where a minor is under sixteen his parent's consent to medical treatment protects the physician from an action for battery, and where the minor is fourteen years of age or over his own consent protects the physician. This seems to permit consent of either parent or minor in the case of the fourteen and fifteen year old.

Turning to Canada, Quebec in 1972 passed the Public Health Protection Act (set out in Appendix A-3). It says that a hospital or a physician may provide care to a minor fourteen years of age or older, but the hospital or the physician must inform the person having parental authority in the case where the minor is sheltered for more than twelve hours, or of extended treatment.

In 1973 British Columbia added to the Infants Act a new section 23 (set out in Appendix A-4). As introduced, the Bill was close to England's, but during the debate it was amended by adding a subsection that said the minor's consent is valid only if "a reasonable effort" has first been made to obtain parental consent, or if a written opinion is obtained from another practitioner that the proposed treatment is in the best interest of the continued health and well-being of the infant. Another subsection empowers the physician, but does not require him, to inform the parent where the minor has been treated without the parent's consent.

The Twelfth Report of British Columbia's Royal Commission on Family and Children's Law reached us as this Report was being drafted in final form. It recommends the repeal of section 23 and the draft Uniform Act prepared by the Conference of Commissioners on Uniform Law and set out in the 1974 Proceedings of the Conference at page 120. As we mention below, the latest draft was prepared after the 1975 meeting. It is close to the 1974 draft except for a change in the definition of medical treatment.

In Saskatchewan a bill (set out in Appendix A-5) was introduced in 1973 to amend the Medical Profession Act. It was much like the English provision though it made an exception in the case of procurement of a miscarriage upon a female person. According to newspaper accounts at the time, the Bill was defeated by a vote of 20 to 22.

Ontario has not enacted any legislation, but the government in 1974 made Regulations 49 and 49a under the Public Hospitals Act, permitting surgical operations and other treatment in hospitals on the consent of a person sixteen years of age or who is married (O. Reg. 100/74). These Regulations are only a partial solution to the problem.

For the past three years the Conference of Commissioners on Uniform Laws has had on its agenda a Uniform Medical Consent of Minors Act (1973 Proc. 24, 228: 1974 Proc. 29, 116). The latest draft was prepared after the 1975 meeting. It is set out as Appendix A-6. Because of the recent mail strike, it has not yet been formally adopted. However we understand that it will probably be adopted soon, and in its present form.

In the draft Uniform Act the basic age for consent is fixed at sixteen years (section 2), and there is a special provision permitting a minor under that age to give his consent where the physician, supported by the opinion of another physician, is of opinion that the minor is capable of understanding the nature and consequence of the treatment, and the treatment is in the best interests of the minor and his continuing health and well-being (section 3(1)). There is also a provision authorizing treatment of a minor under sixteen without any consent in cases of emergency (section 3(2)). Section 4 provides for a court order dispensing with parental consent where such consent is required by law and has been refused, and the minor's life or health is in jeopardy.

We take note here of recent developments in the United States. With fifty separate states there is great variety among the laws dealing with consent to medical treatment of minors. In recent years there has been a marked trend toward legislation that permits minors to give their own consent. Usually this has not been done by the simple fixing of the age of consent at sixteen or some other age below that of majority, but by giving capacity to consent in the case of specified classes of infants or for specified ailments. For example, a statute may say that one or more of the following can consent--one who has been in the Armed Forces, one who has been married, one who has had a child, one who is emancipated, or one who has finished high school. Again, the statute may say that a minor may give his own consent in connection with venereal disease, communicable diseases, drug and alcohol abuse, contraception, or pregnancy. The development of the law in the United States is influenced by constitutional doctrines that have no counterpart in Canada. At the same time, trends in the United States are relevant here, for the practical problems are much the same, and the various American solutions are of interest. For this reason we have set out in Appendix B an account of recent legislation, decisions, and literature.

IV

GENERAL CONSIDERATIONS OF POLICY

Parents have both responsibilities to their children, and rights over them. The parents' role is in large measure a protective one. In deciding whether a young person who is still a minor should have a given capacity, the general test should be whether it is in his own best interests. The law has always afforded to minors some protection from their own immaturity. This is one reason that parents have always had a right of control. An English decision of 1883 says that "the father

has the control over the person, education and conduct of his children until they are twenty-one years of age. That is the law." (Re Agar-Ellis (1883) 24 Ch. D. 317 at 326.) This statement is no longer accurate. In most jurisdictions the mother is guardian along with the father, and rights of guardianship do not remain in full vigor until the minor has reached majority. Lord Denning said in Hewer v. Bryant [1970] 1 Q.B. 357 at 369:

> I would get rid of the rule In re Agar-Ellis and of the suggested exceptions to it. That case was decided in the year 1883. It reflects the attitude of a Victorian parent towards his children. He expected unquestioning obedience to his commands. If a son disobeyed, his father would cut him off with a shilling. If a daughter had an illegitimate child, he would turn her out of the house. His power only ceased when the child became 21. I decline to accept a view so much out of date. The common law can, and should, keep pace with the times. It should declare, in conformity with the recent Report of the Committee on the Age of Majority [Cmnd. 3342, 1967], that the legal right of a parent to the custody of a child ends at the 18th birthday: and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice.

The problem is to strike a proper balance between the desirability, on the one hand, of preserving the protective role of the parents and the desirability, on the other, of ensuring that a person who needs health care is not prevented from obtaining it by inability to secure the consent of his parents or by his unwillingness to disclose to them the condition that needs treatment.

All of the opinions we have received agree that there are situations when a minor should be able to give his own consent. The difficult question is as to the basis on which the minor should be permitted so to consent. The first alternative is between fixing a specified age, e.g. sixteen, or whether some other criterion, such as maturity, should be used. One view put forward strongly on our Board is that there is no need to confer power to consent at any age below that of majority; that minors, even older ones, need protection; that the protective role of the parents should be recognized; and that the "mischief" or weakness in the present law does not require a lowering of the age of consent below eighteen; that there may be cases where the minor should be able to give his own consent, and that these can be covered by a "mature minor" provision, or one like the proposed Uniform section 3(1), or by allowing minors' consent in connection with specific conditions, e.g. venereal disease, drugs, contraception and pregnancy.

We see the force of the argument that it is better to provide for self-consent in specific situations rather than to authorize it at a specific age below that of the age of majority. However we think that the age of sixteen can be justified. There is much literature to the effect that children are maturing earlier than in the past, and leaving home earlier. The opinions we have received are that a great many older minors in Alberta do in fact seek medical advice on their own. We do not think that by fixing the age of consent at sixteen the power to consent will be conferred on those who should not have it. Putting the point affirmatively, the best interests of the minor will be served by permitting him to consent when he has attained the age of sixteen. Then there are two secondary considerations: (1) beginning with England's 1969 Act, it is gaining acceptance, and there is some virtue in uniformity and (2) a specific age

is a more positive guide than a "mature minor" or similar rule. We note that in connection with orders for custody of children, both the Domestic Relations Act and the Child Welfare Act define a child as a person under eighteen, whereas under the Maintenance Orders Act a child is one under sixteen. However in connection with custody, we are informed that the invariable practice in this province is for judges to refuse to grant a custody order when the minor has reached sixteen years of age.

Recommendation #1

That the general age for consent to health care be fixed at sixteen years.

V

SPECIAL SITUATIONS

Here we speak of (1) venereal disease (2) drugs and alcohol (3) contraception and (4) pregnancy and its termination.

If the only minors seeking advice or treatment in connection with these conditions were sixteen years of age or more then there would be no need to deal specially with them. The minor could give his own consent under the general provision. We understand however that some minors who require treatment are in fact under sixteen years of age. We think that minors who are old enough to need attention in connection with these matters should be able to obtain it themselves. In every one of these situations we understand there is a special reluctance to inform parents, and that the minor will be harmed by failure to obtain treatment, or even by delay in obtaining it. The opinions we have received as well as the literature we have examined supports this position.

We shall now consider in detail the four special situations listed above.

(1) Venereal Diseases

The Veneral Diseases Prevention Act RSA 1970 Chapter 382 requires every person who knows or who suspects or who has reason to believe that he has venereal disease to consult a physician or attend a provincial clinic to determine whether he is infected or not; and if infected he is required to submit to treatment. Moreover, the Director of the Division of Social Hygiene of the Department of Health and Social Development has power to compel a person with venereal disease to submit to medical treatment; and there is provision for a magistrate's warrant to take the person into custody for examination and treatment; and a jail physician may order the examination and treatment of persons arrested for certain sexual offences and of convicted persons. The Act does not refer to minors. We are satisfied that it applies to them, and our information is that in fact they are treated under the Act. We have had comments, some adverse, on the Act. We note, too, that a Liaison Committee of the Canadian Medical Association and the Canadian Bar Association in its 1974-75 report included a resolution recommending to the two Associations the repeal of existing provincial legislation respecting the control of venereal disease, except insofar as the patient refusing treatment is concerned. It also recommended the repeal of section 253 of the Criminal Code, which makes the communication of venereal disease a criminal offence.

We do not plan here to make any recommendations in connection with the Venereal Diseases Prevention Act. We think however that venereal disease should be mentioned specifically in the Act which we propose. Our understanding

is that sometimes persons under sixteen years of age contract venereal disease. Prompt treatment is essential, and a requirement of parental consent might result in delay or even in neglect of treatment. If a person is old enough to contract venereal disease he should have the capacity to attend to it; and provision for self-consent would not conflict in any way with the Venereal Diseases Prevention Act. Some of the American statutes extend the provision respecting venereal disease to all communicable or reportable diseases. In connection with the present subject of consent to medical treatment, venereal disease is the most important. However we think it appropriate to permit self-consent in the case of all communicable diseases as defined in the Public Health Act. There is a public interest in having them treated and treatment can scarcely be contrary to the minor's consent.

(2) Drugs and Alcohol

The reasoning we have advanced in connection with venereal disease is applicable here. A few years ago the University of Alberta Hospital established a program called the Trust House for treatment of young people who had taken drugs. Our information is that there was some reluctance to attend because of fear the hospital would inform legal authorities and parents. The Hospital Board made a decision to treat minors in the Emergency Department for drug related problems without notifying the parents. We are informed that when this decision was made, the volume of young people who then came to the Emergency Department increased rapidly and considerably and stayed at an increased level for quite some time. We emphasize that although the hospital observed confidentiality, the physicians in charge of the programme did try to convince the patients of the benefits to be gained in the long run in voluntarily informing their parents, and offered to assist them in doing so.

Our recommendation is that any minor who wishes medical care in connection with drugs or alcohol should be able to give his own consent to treatment.

(3) Contraception

All of the physicians and others who have commented on our memorandum are of opinion that minors should be able to seek contraceptive advice and devices or prescriptions. We are not able to document an increase in sexual activity among minors but all the information we have received is that it is considerable. We have the figures on births in Alberta in 1973, the latest year available. There were 29,288 births of which 3,220 were illegitimate.

The number of illegitimate children born to girls under twenty were as follows:

13 years	-	4
14 years	-	35
15 years	-	88
16 years	-	245
17 years	-	375
18 years	-	391
19 years	-	411

These figures show that over 23% of the illegitimate children were born to minors; and over 12% to eighteen-year old girls, many of whom presumably became pregnant while minors. The representations we have received strongly support provision for giving contraceptives to minors regardless of age.

The principal argument advanced against such a provision is that it will encourage minors to engage in sexual

intercourse. The answer that we have received is that the withholding of contraceptive advice is not a deterrent; and granted that minors are engaging in sexual intercourse, it is better for the minor to be able to avoid unwanted pregnancies. We accept that answer and will make our recommendation accordingly.

One concern that physicians and social workers may have is whether the giving of advice and prescriptions for contraception constitutes the offense of contributing to delinquency under the Juvenile Delinquents Act. In our opinion it does not. It is relevant to note that the Criminal Code no longer makes it an offence to advertise or sell or dispose of contraceptives. The amendment was made in 1969 and at the same time the Food and Drug Act was amended to provide for regulation of advertisements for contraceptives.

In Alberta girls under eighteen and boys under sixteen are children for the purpose of the Juvenile Delinquents Act RSC 1970 Chapter J-3. A juvenile delinquent is "any child who violates any provision of the Criminal Code...or who is guilty of sexual immorality or any similar form of vice..." (section 2(11)). Section 33, which makes it an offence for adults to contribute to juvenile delinquency reads:

> (1) Any person, whether the parent or guardian of the child or not, who knowingly or wilfully,
>
> (a) aids, causes, abets or connives at the commission by a child of a delinquency, or,
>
> (b) does any act producing, promoting, or contributing to a child's being or becoming a juvenile delinquent or likely to make any child a juvenile delinquent,

> is liable on summmary conviction before a juvenile court or a magistrate to a fine not exceeding five hundred dollars or to imprisonment for a period not exceeding two years, or to both.

We know of no instance in which a physician has been charged with contributing by reason of prescribing contraceptives. In a case from Quebec in 1969, X v. The Queen [1969] RL 122 a boy of nineteen was charged with contributing because he had had sexual intercourse three or four times over a period of six months with a sixteen-year old girl. The court acquitted, holding that the act in itself is not criminal or immoral. We realize that many will disagree with the finding on immorality. However, the position of the physician who prescribes contraceptives is vastly different from that of an adult who has intercourse with a juvenile. The physician's motivation is not to induce the minor to have sexual intercourse, but to provide health care for the minor who is having sexual intercourse and wishes to avoid pregnancy. Although there may be some room for doubt, it is our opinion that the physician does not contribute to delinquency.

We note that the federal government proposes to replace the Juvenile Delinquents Act by the Young Persons in Conflict with the Law Act. We refer to the Report of the Solicitor General's Committee for New Legislation to replace the Juvenile Delinquents Act (Cat. No. JS42-3/75). It would do away with the concept of delinquency. It would apply to persons fourteen years of age and over but below eighteen. The Act would come into play only where there has been a breach by a young person of an Act of Parliament. The offence of contributing would disappear.

There is one provision in the Criminal Code that must be considered. It is section 146 which provides:

> 146.(1) Every male person who has sexual intercourse with a femal person who
>
> (a) is not his wife, and
>
> (b) is under the age of fourteen years, whether or not he believes that she is fourteen years of age or more, is guilty of an indictable offence and is liable to imprisonment for life and to be whipped.
>
> (2) Every male person who has sexual intercourse with a female person who
>
> (a) is not his wife,
>
> (b) is of previously chaste character, and
>
> (c) is fourteen years of age or more and is under the age of sixteen years,
>
> whether or not he believes that she is sixteen years of age or more, is guilty of an indictable offence and liable to imprisonment for five years.
>
> (3) Where an accused is charged with an offence under subsection (2), the court may find the accused not guilty if it is of opinion that the evidence does not show that, as between the accused and the female person, the accused is more to blame than the female person.

Let us assume that a physician has prescribed contraceptives to a girl under sixteen. Could he possibly be guilty of aiding and abetting an offence under section 146? We think not. The offence can only be committed by a male and the physician's action is not for the purpose of assisting the male in the commission of the offence. A similar question has come up in England. Section 6 of the Sexual Offenders Act 1956 makes it an offence for a man to have sexual intercourse with a girl under sixteen. (The narrow exceptions are irrelevant.) Another statute, the National

Health Service (Family Planning) Act 1967 authorizes local health authorities to "make arrangements for the giving of advice on contraception, the medical examination of persons seeking advice on contraception for the purpose of determining what advice to give and the supply of contraceptive substances and contraceptive appliances." A report of the Medical Defense Union on Consent to Treatment (1974) contains the following passage at page 9:

> Following the introduction of the National Health Service (Family Planning) Act 1967 many members wrote asking whether a doctor who in good faith gives contraceptive advice or prescribes, supplies or fits contraceptive devices to a girl under the age of 16 years, commits any criminal offence. It was thought that by doing so a doctor might be regarded as aiding and abetting the offence of having unlawful sexual intercourse, since a substantial reason for restraint in the girl's sexual conduct would be removed by the doctor's guidance. The Union's legal advisers state that it is for the doctor to decide whether to provide contraceptive advice and treatment and if he does so for a girl under the age of 16 he is not acting unlawfully provided he acts in good faith in protecting the girl against the potentially harmful effects of intercourse.

We think this reasoning sound, and that it furnishes an answer to any suggestion that a physician in prescribing contraceptives could be guilty of aiding and abetting an offence under section 146.

Before leaving this subject we make note of an English Report made in April 1974 by a Committee on the Working of the Abortion Act, popularly called the Lane Committee. Its discussion of the question "For Whom Should Contraception Be Made Available?" is of some interest here. We have set out in Appendix C the relevant paragraphs of the Report.

It is convenient here to mention a problem that has arisen in connection with contraceptive advice to minors, though it could arise in connection with treatment for venereal disease or drugs or in connection with pregnancy. It is an ethical question, not a legal one. Where the physician treats a minor patient, is he ethically obliged to tell the parents, or at least privileged to do so, notwithstanding the general rule of confidentiality? We shall note here two disciplinary proceedings that deal with this ethical issue.

(1) In British Columbia a physician was found guilty of infamous or unprofessional conduct in supplying a birth control device to a fifteen-year old female patient without parental consent, and in intentionally not disclosing further treatment to the parents. In upholding the ruling the court did not say that the physician is always obliged to inform the parents but held that in this case he was. The mother had in fact been in touch with the physician. (Re "D" and Counsel of the College of Physicians and Surgeons of British Columbia (1970) 11 D.L.R. (3d) 570.)

(2) The British Medical Journal for 20 March 1971 page 620 discusses an English case in which a sixteen-year old girl was prescribed contraceptives by a birth control centre. The centre informed the family physician. He disagreed with the prescription and informed the parents. The centre complained to the governing medical body that the physician had committed a breach of the duty of confidentiality. The complaint was dismissed. The test was the patient's interest. The article expresses the opinion that as a general rule the physician should observe confidentiality.

We make no comment on the ethics of the medical profession as reflected in these two disciplinary proceedings.

We have, however, considered whether our proposed legislation should provide for confidentiality. We are aware that Quebec's statute imposes on the physician an obligation (in most cases) to inform the parents, and that British Columbia's 1973 amendment confers on the physician a privilege of informing the parents. We accept the general proposition that it is better for minors to take their parents into their confidence. Our understanding is that the practice of physicians is to try to persuade young patients to do this. If the patient agrees there is no problem. The hard issue arises when the minor is adamant in refusing. We think that in these circumstances the usual obligation of confidentiality should apply. This formal recommendation is set out later.

(4) Pregnancy and Its Termination

In Alberta nearly every minor who becomes pregnant is unmarried. We have already given figures for 1973 of births to girls who are minors. In connection with abortions, the Alberta Hospital Services Commission has provided us with the number of therapeutic abortions in hospitals in Alberta in 1974 and in the first six months of 1975. A therapeutic abortion is one that has been carried out in accordance with the Criminal Code. That is to say, a committee has found that an abortion is necessary in the interest of the mother's life or health. We have no statistics on illegal abortions.

In 1974 there were 4,462 therapeutic abortions in Alberta. Of these 62 were of persons under fifteen years of age, all single: 1,636 were of persons in the 15-19 age bracket, of whom 1,582 were single. In the first six months of 1975, 37 were of persons under fifteen years of age, all single: 775 were of persons in the 15-19 age bracket, and of these 747 were single.

The age group 15-19 of course includes some who are minors and some who are not. The statistics do not segregate them. If the age for consent is fixed at sixteen, then the great majority of those in the 15-19 age bracket will be able to give their own consent and only those who are fifteen years of age or younger will be unable to do so.

If sixteen is to be fixed as the general age of consent, then it will apply in connection with treatment for pregnancy and its termination. There remains the case of those minors who are under sixteen.

Some of the opinions we received were that in the case of very young girls (that is under sixteen) who have become pregnant, parental consent to an abortion should be required along with the girl's own consent. The majority however thought not.

Pregnancy is a trying experience for a young person, and especially one who is unmarried. It is best that the daughter should inform her parents and seek their help and support. The decision whether the pregnancy should continue to term or whether an abortion should be sought within the terms of the Criminal Code is a very important one, and doubtless difficult. We think that the decision should be the girl's. Whichever it is it should not be subject to veto by a parent.

A question related to that of parental consent is whether the physician should be obliged to notify the parents. This is of course the same question that we have mentioned in connection with drugs and also contraception. The opinions we received emphatically state that the minor patient is like any other and that confidentiality should be observed. In

other words the physician should not notify the parents without the patient's consent. We agree. One of the American Model Acts puts such a provision in the statute. We think this unnecessary, because the general law permits the patient to release the physician from his obligation of confidentiality.

Formal Recommendation on the Four Conditions

Before coming to our formal recommendation we point out that the proposed Uniform Act (Appendix A-6) in section 3(1) provides for consent by a minor under sixteen where in the practitioner's opinion, supported by that of another practitioner, (a) the minor is capable of understanding the nature and consequences of the medical treatment and (b) the medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well-being.

We recognize that a section of this kind could be used in connection with a patient under sixteen who seeks medical aid in connection with the four conditions we have described as special. We have considered at length whether we should recommend Uniform section 3(1) as the best way to deal with those conditions. Ultimately we have concluded that it would be better specifically to name them and to permit the minor to seek his own medical aid in connection with them. Recommendtion #2(1) set out below, embodies this policy. A question could arise as to whether the parents' power to consent has been removed in connection with these four conditions where the minor is under sixteen years of age. We think that in these circumstances the physician should be able to act on the consent of either minor or parent. This is not the same as a requirement of double consent. There could however be a problem where the parent consents and the

minor refuses. The only occasion in which this is likely to arise is where the minor under sixteen refuses to terminate pregnancy and the parent consents to such termination. The decision whether to terminate is the physician's. However if he does do so our recommendation will protect him should the minor allege that the medical procedure constitutes a battery.

Recommendation #2

> *(1) That a minor of any age may consent to health care in connection with any communicable disease, drug or alcohol abuse, prevention of pregnancy, and pregnancy and its termination.*
>
> *(2) That where the minor is under the age of sixteen years his power of consent under this recommendation is alternative to that of his parent or guardian.*

We considered whether to include in this recommendation the matter of emotional disturbance or disorder as do some American laws or proposed laws. We decided against it because we are not satisfied of the necessity, and because the terms "emotional disturbances" and "emotional disorders" are vague and could be given a very broad interpretation.

VI

THE CHILD OF THE MINOR MOTHER

Although a minor sixteen years of age will be able to give her own consent to medical treatment in general, and a minor of any age will be able to give her own consent to treatment in connection with the four specific situations discussed above, the question might arise as to the power of a minor to give consent to the treatment of her own child.

It would be completely anomalous for her to be unable to authorize such treatment. Perhaps such a power is implied without statutory authorization. None of the Commonwealth legislation or proposed legislation that has come to our attention deals with this matter. In the United States, on the other hand, fourteen of the states have laws covering this point. Most of them are recent. We think there should be specific provision enabling any minor who is a mother to give consent to medical treatment for herself and her child. It might seem unnecessary to include "herself", because in most cases she would have capacity to consent by virtue of the earlier recommendations. However they would not cover the case of a fifteen-year old mother--at least not completely.

Recommendation #3

> *That a minor who has borne a child may consent to health care for herself and her child.*

VII

EMERGENCIES

Although there is not a great deal of case law on the subject, the well-known Nova Scotia case of Marshall v. Curry [1933] 3 D.L.R. 260 holds that a physician may perform an operation without consent where necessary to save the life or preserve the health of the patient. In a recent Ontario case, Schweizer v. Central Hospital (1975) 53 D.L.R. 494, the patient consented to an operation on his foot. The surgeon operated on his spine. After pointing out that surgical interference is an assault in the absence of consent, the judgment adds by way of dictum: "The only exception lies in the case of emergency where it is not practicable to obtain the patient's consent or the consent of someone of his behalf, and where the

surgeon deems it necessary to immediately take some action for the preservation of the life or health of the patient." (Skegg, A Justification for Medical Procedures Performed Without Consent (1974) 90 L.Q.R. 512 at 514-519, discusses this subject.)

Alberta has an Emergency Medical Aid Act, R.S.A. 1970 Ch. 122. Passed in 1969, it is a "good Samaritan law". It says that a person rendering emergency aid is liable only for gross negligence. However an amendment of 1974 (1974 Ch. 26) adds a new section 4. It is set out as Appendix D. It deals with adults and not with minors. It is not really an emergency provision, though in our opinion it is wide enough to include emergency treatment. Our understanding is that its main purpose is to permit treatment of adults who by reason of mental incapacity cannot give their own consent. In any case it does not deal with minors.

We have considered whether to recommend a provision covering emergency medical aid to infants. The draft Uniform Act (Appendix A-6) in section 3(2) provides for minors who cannot consent, where the practitioner is of opinion that the medical treatment is necessary in an emergency to meet imminent risk to the minor's life or health. For reasons of which we are not aware, this provision is restricted to minors under sixteen.

After lengthy consideration we have decided not to recommend the inclusion of an emergency provision in the proposed Act. The reasons are:

(1) the proposed Act deals with consent, and the law as to emergencies deals with a situation where there is no consent;

(2) we should not codify the law on emergencies with regard to part of the population.

It may be that the law on medical emergencies in general could be an appropriate subject for study as a law reform project. However, this is not the place for it. To make it clear that we intend to preserve the existing law as to treatment in emergencies we recommend the following:

Recommendation #4

That nothing in the proposed Act affects the law relating to the administration of health care in emergencies.

VIII

PARENTAL REFUSAL OF HEALTH CARE FOR MINORS

We have considered the question whether the proposed Act should provide for treatment of a minor who is in law incapable of giving his own consent and where the parents have neglected or refused to provide medical care. The proposed Uniform Act in section 4 provides that where parental consent is refused or not obtainable anyone may apply for an order to dispense with parental consent. The court may give the order if satisfied that the withholding of the treatment would endanger the life or seriously impair the health of the minor. Quebec's statute (Appendix A-3) has a similar provision, though it applies only where the child is under fourteen years of age.

All of the common law provinces have a Child Welfare Act or its equivalent. (In British Columbia it is the Protection of Children Act, in Prince Edward Island the Children's Protection Act, and in Saskatchewan the Family Services Act.)

These statutes have much in common. A neglected child (or in some statutes, a child in need of protection) is defined to include many categories. In Alberta's Child Welfare Act the definition of "neglected child" is found in section 14. One of the categories is

> "(x) a child where the person in whose charge he is neglects or refuses to provide or obtain proper medical, surgical or other remedial care or treatment necessary for his health or well-being, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a duly qualified medical practitioner."

Where a child is neglected, the general scheme of all the legislation is to provide for apprehension of the child, for example by the Director of Child Welfare, and to apply to a judge for an order declaring the child to be a neglected child. If he is so declared then he may be placed in the custody of the Director of Child Welfare or in some provinces, of a Children's Aid Society. After the order has been made, the person having custody can authorize medical treatment. However there are cases where the need of medical attention is urgent at the very moment when the child is apprehended. No problem appears to arise where the case is one of neglect. The problem arises where the parents refuse a certain type of treatment, such as a blood transfusion, on religious grounds. Although these cases are not frequent they are of course difficult and require the weighing of society's interest in the child's well-being against society's interest in respecting the parents' religious beliefs.

When Alberta's Child Welfare Act was completely revised in 1966, new provisions were included for the purpose of dealing with this problem. A hospital in which a child is

a patient is made a shelter under the Act, and more important, seciton 17 provides:

> 17.(1) During the time a child is detained in custody pursuant to section 16 the authority who apprehended the child,
>
> (a) is responsible for his care maintenance and well-being, and
>
> (b) may authorize the provision of such medical, surgical and psychiatric care as the authority considers necessary, without the consent of the parent or guardian and without an order of a court.
>
> (2) No liability attaches to the authority or to a duly qualified medical practitioner or to a hospital by reason only that a child is provided with medical, surgical or psychiatric care as mentioned in subsection (1).

This provision applies before any order has been made by a judge on the question whether the child is a neglected child. The hearing on the question whether the child is neglected must be held before a judge within 20 days of the date of apprehension (section 18). Under the Alberta Act the right of the Director to authorize medical treatment, even in the face of the parents' refusal, exists from the moment of apprehension and does not have to await the judicial finding.

As to the law in the other provinces, Newfoundland's Child Welfare Act (1972) No. 37 contains in section 11 provisions that seem to be modelled closely on Alberta's. In the other provincial Acts we have not found specific provisions for medical treatment of the child prior to court order and in the face of parental refusal.

It is relevant to note that under our Child Welfare Act, "child" is a person under eighteen years of age. It will be recalled that we propose to give the power of self-consent to minors of seventeen and sixteen, and in certain cases to minors of a younger age.

Our understanding of the reason for section 4 in the Uniform Act is that the procedure under the typical Child Welfare Act is too slow and cumbersome and that it should not be necessary to have a declaration that the child is a neglected child in order to treat him in the face of parental refusal. Should Uniform section 4 be enacted in Alberta?

We spent much time on this question, and finally decided, though not unanimously, that section 4 would be of some value as an alternative procedure to that provided in the Child Welfare Act. In the following recommendation subsections (1) and (2) are the same as Uniform section 4. Applications are to be made to the Supreme Court. We point out, however, that by virtue of section 43 of the District Courts Act as amended in 1975 (1975 c.43 s.1(3)), judges of the District Court will have jurisdiction.

We shall now explain subsections (3) and (4) of the following recommendation. It will be recalled that under the Child Welfare Act, a person can be a neglected child up to the age of eighteen. We have recommended that a minor have capacity to give his own consent at sixteen. Thus it would be inappropriate to have a sixteen or seventeen year-old minor declared a neglected child because of his parents' neglect to provide medical treatment. The purpose of subsection (3) is to remove this possibility. The purpose of subsection (4) is to prevent competing procedures where parents, being entitled to give consent, have refused to do so. It would be unwise to

permit two separate procedures to exist side by side for the purpose of procuring medical aid in the event of parental refusal. Thus subsection (4) of the following resolution provides that the new statutory procedure shall not be available where the child has been apprehended pursuant to section 16 of the Child Welfare Act.

Recommendation #5

> *(1) Where the consent of a parent or guardian to medical treatment of a minor is required by law and is refused or otherwise not obtainable, any person may apply to the Supreme Court for an order dispensing with the consent.*
>
> *(2) The court shall hear the application in a summary manner and may proceed ex parte or otherwise and, where it is satisfied that the withholding of the medical treatment would endanger the life or seriously impair the health of the minor, may by order dispense with the consent of the parent or guardian to such medical treatment as is specified in the order.*
>
> *(3) That the Child Welfare Act be amended to make it clear that section 17 does not authorize the giving of medical treatment to a child who has attained the age of sixteen years.*
>
> *(4) That no application shall be made under subsection (1) of this recommendation, in the case of a minor under the age of sixteen years who has been apprehended under section 16 of the Child Welfare Act.*

We have mentioned that the recommendation to enact Uniform section 4 was not unanimous. The minority view was that the provisions of the Child Welfare Act are satisfactory and that there is no need of another procedure that excludes the participation of the Director of Child Welfare.

IX
STERILIZATION

We speak here of surgical sterilization and not of temporary sterilization that may be said to result from contraceptive measures. We are not here concerned with the general subject of voluntary sterilization as a form of family planning but only with the question whether a minor should be able to consent to his or her own sterilization. We understand that in theory it is reversible both for women and men, but that for practical purposes it is irreversible. The opinions we have received are unanimous that a minor should not be able to consent to sterilization. We agree.

Recommendation #6

That nothing in the proposed Act permits a minor to consent to surgical sterilization.

This recommendation will be embodied in the definition of health care.

X
CONFIDENTIALITY AND THE ALBERTA HEALTH PLAN

We have supported the basic principle of confidentiality as between physician and patient. Our attention was called to the fact that under the Alberta Health Plan the Health Care Insurance Commission sends to the insured person a statement covering every six-month period. It lists the medical care that has been provided to all members of the family of the insured. This creates no problem in general. However a member of the family who is a minor may go to a physician, e.g. in connection with drugs; and the listing of this item on the half-yearly statement to the insured operates

to remove the patient-physician confidentiality. We are told that physicians sometimes request the Commission to omit an item from the annual statement because the patient does not want his or her parents to know. The Commission has invariably obliged. These requests are increasing in number and there may be doubt as to the authority of the Commission to withhold the information. We have not examined this question.

It was suggested to us that in this Report we make recommendations to clarify the right of the Commission in this respect. We do not think that this is a matter we should attempt to include in the present Report. To deal with it would require much information, analysis of the legislation and discussions with those involved, and we think it is really outside the scope of the present project. This is not to say that we do not recognize the importance of the problem in its bearing on patient-physician confidentiality.

XI
MISCELLANEOUS POINTS

There are a few items which we note here because they came up during our study.

(1) Should the Act refer to hospitals as well as to medical and dental practitioners? Quebec's Act does this, and so do some of the American statutes. We do not think it is necessary.

(2) Should the Act refer to nurses and other para-medical personnel, and to social workers who may refer a minor to a physician or to a clinic. We think the definition of health care will cover the first category, and that there is no need to refer to social workers.

(3) Should the Act require that the minor's consent be an informed consent, and should that phrase be defined? We note that the Human Tissue Gift Act 1973 Ch. 71 says in section 3(1) that on an inter vivos gift of human tissue, the donor must be one who "is able to make a free and informed decision". In our opinion the proposed Act should not attempt to deal with informed consent. That phrase is not peculiar to treatment of minors, but applies generally. There is the further fact that "informed consent" is hard to define. The leading cases in Canada are two in the Ontario Court of Appeal: Kenny v. Lockwood [1932] 1 D.L.R. 507 and Male v. Hopmans (1967) 64 D.L.R. (2d) 105. In the United States there is a recent trend toward much more exacting requirements. The leading cases are Canterbury v. Spence (1972) 464 F. 2d 772, and Cobbs v. Grant (1972) 104 Cal. Reptr. 505. According to those cases the basis for an informed consent is more like that laid down by the Saskatchewan Court of Appeal in Halushka v. University of Saskatchewan (1965) 53 D.L.R. (2d) 436, which had to do with experimentation on a healthy person, and not with medical treatment. We think that it would be unwise to attempt a definition of informed consent at the present time, and that in any event it does not belong in a statute dealing exclusively with minors.

(4) Should there be provision for liability for the physician's account? Some of the American Acts specify that the minor is liable for the account. We see no need in an act dealing with consent to consider the matter of payment of the account, especially in the light of the Alberta Health Care Plan.

(5) Need provision be made for withdrawal of consent? Some of the American Acts specifically say that the minor having consented may not withdraw his consent after

the treatment has been given. We think it obvious that the minor cannot so withdraw, and see no need so to specify in the statute.

(6) Need any reference be made to the Human Tissue Gift Act to make it clear that that Act is not affected by the proposed statute? A note to the draft Uniform Act says "[Additional sections may be added in the respective jurisdictions to reserve the special provisions found in the Human Tissue Gift Act concerning consent to inter vivos human organ transplant.]" Alberta has that Act (1973 Ch. 71). We see no need to refer to it. It could not possibly be affected by the proposed Act. The donation of tissue is not health care for the donor; and moreover the power of a sixteen-year old person to consent to health care as though he were of the age of majority does not put him above the age of majority for the purpose of the Human Tissue Gift Act.

(7) Should provision be made to cover the case of the minor who misrepresents his age? We think this should be provided for along the lines of section 3(2) of the Human Tissue Gift Act.

Recommendation #7

> *That a consent given by a person who has not attained the age of sixteen years of age is valid if the medical or dental practitioner had no reason to believe that the person who gave it had not attained the age of sixteen years.*

(8) Earlier, in connection with contraception we referred to the matter of patient-physician confidentiality. We emphasize that in our opinion the obligation of confidentiality should apply generally, and the following recommendation is designed to effect that policy.

Recommendation #8

That the usual physician-patient confidentiality shall apply to health care to which a minor has consented pursuant to the proposed Act.

XII

DEFINITIONS

Many of the Acts contain a definition of medical treatment or health care. We think it appropriate to use the term "health care" and to define it. Our definition is as follows:

Recommendation #9

"Health care" means treatment by a qualified medical or dental practitioner in the course of his practise, and includes mental and surgical care, prevention and diagnosis of disease or ailment, the administration of anesthetics, procedures for the purpose of preventing pregnancy, and treatment given by any person pursuant to directions given in the course of practise by a qualified medical or dental practitioner, but does not include surgical sterilization.

XIII

DRAFT ACT

For convenience we have put our recommendations in the form of a draft statute which is attached as Appendix E. As we have pointed out in other reports, we realize that the legislative draftsman may make changes.

XIV
ACKNOWLEDGMENTS

We have received a great deal of help from various persons in the fields of medicine, government and social work. This has consisted of replies to the memorandum mentioned earlier, and of a number of interviews, some of them lengthy. The letters we have received were invariably thoughtful, responsible and constructive. We have set out in Appendix F the names of all of the persons who have assisted us.

We acknowledge too the most helpful research paper prepared by Mrs. van der Ven and mentioned earlier, and also her continuous invaluable help on this project.

W. F. BOWKER
R. P. FRASER
WILLIAM HENKEL
W. H. HURLBURT
ELLEN JACOBS
FREDERICK LAUX
W. A. STEVENSON

By: _____
Chairman

_____
Director

December 29, 1975

APPENDIX A

APPENDIX A-1

England

Family Law Reform Act, 1969 c. 46

8.(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

(2) In this section "surgical, medical or dental treatment" includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.

(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

APPENDIX A-2

New South Wales

Minors (Property and Contracts) Act, 1970 No. 60

49. (1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has

effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.

(2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his consent has effect in relation to a claim by him for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he were aged twenty-one years or upwards.

(3) This section does not affect--

(a) such operation as a consent may have otherwise than as provided in this section; or

(b) the circumstances in which medical treatment or dental treatment may be justified in the absence of consent.

(4) In this section--

"dental treatment" means--

(i) treatment by a dentist registered under the Dentists Act, 1934, in the course of the practice of dentistry; or

(ii) treatment by any person pursuant to directions given in the course of the practice of dentistry by a dentist so registered; and

"medical treatment" means--

(i) treatment by a medical practitioner in the course of the practice of medicine or surgery; or

(ii) treatment by any person pursuant to directions given in the course of the practice of medicine or surgery by a medical practitioner.

APPENDIX A-3

Quebec

Public Health Protection Act, 1972, c. 42

36. An establishment or a physician may provide the care and treatment required by the state of health of a minor fourteen years of age or older with his consent without being required to obtain the consent of the person having paternal authority; the establishment or the physician must however inform the person having parental authority in the case where the minor is sheltered for more than twelve hours, or of extended treatment.

Where a minor is under fourteen years of age, the consent of the person having paternal authority must be obtained; however, if that consent cannot be obtained or where refusal by the person having paternal authority is not justified in the child's best interest, a judge of the Superior Court may authorize the care or treatment.

37. An establishment or a physician shall see that care or treatment is provided to every person in danger of death; if that person is a minor, the consent of the person having paternal authority shall not be required.

For a discussion of the history of these sections see Crepeau, Le Consentement du Mineur en Matière de Soins et Traitements Médicaux ou Chirurgicaux Selon le Droit Civil Canadien (1974) 52 Can. Bar Rev. 247 at 248-251.

APPENDIX A-4

British Columbia

Infants Act Amendment Act, 1973, c. 43

23.(1) Subject to the provisions of subsection (3), the consent of an infant who has attained the age of sixteen years, to any surgical, medical, mental, or dental treatment which, in the absence of consent, would consitute a trespass to his person, shall be as effective as it would be if he were of full age; and where an infant has, by virtue of this section, given his consent to any treatment it shall not be necessary to obtain any consent from his parent or guardian.

(2) In this section, "surgical, medical, or mental treatment" means any procedure undertaken by a duly qualified medical practitioner, and "dental treatment" means any procedure undertaken by a dentist who is a member of the College of Dental Surgeons of British Columbia, for the purpose of diagnosis or treatment, including in particular the administration of an anaesthetic, or any other procedure which is ancillary to the diagnosis or treatment.

(3) Nothing in this section shall be construed as making effective any consent of an infant unless

(a) a reasonable effort has first been made by the medical practitioner, or the dentist, as the case may be, to obtain the consent of the parent or guardian of such an infant; or

(b) a written opinion from one other medical practitioner or dentist, as the case may be, is obtained confirming that the surgical, medical, mental, or dental treatment and the procedure to be

undertaken is in the best interest of the continued health and well-being of the infant.

(4) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

(5) Notwithstanding that, under subsection (1), an infant is treated without consent from his parent or guardian, the duly qualified medical practitioner or dentist who treats the infant may provide the parent or guardian of the infant with such information as the person treating the infant may consider advisable.

For a criticism of this section see Gosse, Consent to Medical Treatment: A Minor Digression (1974) 9 U.B.C. L. Rev. 56.

APPENDIX A-5

Saskatchewan

Bill to Amend the Medical Profession Act, No. 101, 1973

69A.-(1) Subject to subsection (3), the consent of a person who has attained the age of sixteen years to a service provided by a person registered under this Act and not under suspension which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were eighteen years of age or over.

(2) Subject to subsection (3), where a person who has attained the age of sixteen years consents to any service provided by a person registered under this Act and not under suspension in respect of his person, it is not necessary to obtain any consent for that service from his parent or guardian.

(3) Subsections (1) and (2) do not apply to the procurement of a miscarriage upon a female person by a person registered under this Act and not under suspension.

(4) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

2. This Act comes into force on the day of assent.

APPENDIX A-6

Uniform Law Conference of Canada

Medical Consent of Minors Act, Draft, 22 September 1975

1. In this Act "Medical treatment" includes

(a) surgical and dental treatment,

(b) any procedure undertaken for the purpose of diagnosis,

(c) any procedure undertaken for the purpose of preventing any disease or ailment,

(d) any procedure undertaken for the purpose of preventing pregnancy, and

(e) any procedure that is ancillary to any treatment as it applies to that treatment.

2. The law respecting consent to medical treatment of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority.

3.(1) The consent to medical treatment of a minor who has not attained the age of sixteen years is as effective as it would be if he had attained the age of majority where, in the opinion of a legally qualified medical practitioner or dentist attending the minor, supported by the written opinion of one other legally qualified medical practitioner or dentist, as the case may be,

(a) the minor is capable of understanding the nature and consequences of the medical treatment, and

(b) the medical treatment and the procedure to be used is in the best interests of the minor and his continuing health and well-being.

(2) The consent of a minor who has not attained the age of sixteen years or of his parent or guardian is not required in relation to medical treatment performed with respect to that minor where

(a) the minor is incapable of understanding the nature and consequences of the medical treatment, or being capable of understanding the nature and consequences of the medical treatment, is incapable of communicating his consent to the medical treatment, and

(b) a legally qualified medical practitioner or dentist attending the minor is of the opinion that the medical treatment is necessary in an emergency to meet imminent risk to the minor's life or health.

4.(1) Where the consent of a parent or guardian to medical treatment of a minor is required by law and is refused or otherwise not obtainable, any person may apply to (insert court as appropriate to the jurisdiction) for an order dispensing with the consent.

(2) The court shall hear the application in a summary manner and may proceed ex parte or otherwise and where it is satisfied that the withholding of the medical treatment would endanger the life or seriously impair the health of the minor, may by order dispense with the consent of the parent or guardian to such medical treatment as is specified in the order.

5. Where, by or under this Act, the consent of the parent or guardian of a minor to his medical treatment is not required or is dispensed with, the medical treatment does not for the reason that the consent of the parent or guardian was not obtained, constitute a trespass to the person of the minor.

NOTE:

1. A jurisdiction considering enactment of this Act may wish to exclude particular kinds of procedures from its scope, e.g., sterilization or procurement of miscarriage. In the case of any exclusion, however, consideration must also be given as to whether or not the exclusion is to apply generally or only with respect to section 3.

   [Additional sections may be added in the respective jurisdictions to reserve the special provisions to be found in the Human Tissue Gift Act concerning consent to inter vivos human organ transplant.]

2. Each jurisdiction considering the enactment of this Act should also consider what amendments, if any, are required in relation to the provisions in its Child Welfare Act dealing with children who are neglected by reason of lack of medical care and with the procedures for making those children wards of the Government for the purpose of enabling medical care to be provided to them.

APPENDIX B

United States:
Recent Cases, Statutes and Literature

In the last five or six years there has been much preoccupation with the minor's right to medical treatment, and particularly in connection with contraception and abortion. Does legislation restricting the minor's right to consent to medical treatment deny to him due process of law or equal protection of the law?

In connection with contraception the Supreme Court in Griswold v. Connecticut (1965) 381 U.S. 479 held invalid a state law that made it a crime to use contraceptives. The law infringed the right of privacy of married couples, and the majority of the court found such right to be constitutionally protected. Then in Eisenstadt v. Baird (1972) 405 U.S. 438 the court considered a Massachusetts law forbidding the distribution of contraceptives except by a physician to a married couple. The court held it invalid. The state failed to show a valid reason for distinguishing between married persons and unmarried, so the Act denied to unmarried persons the equal protection of the law.

Then in connection with abortion, the well-known cases of Roe v. Wade (1973) 410 U.S. 113 and Doe v. Bolton (1973) 410 U.S. 179 held that a state could not validly interfere with a woman's right to procure an abortion during the first trimester of pregnancy. The emphasis, as in Griswold, was on the right of privacy. We in Canada are not concerned with the constitutional basis for these judgments. Indeed the Supreme Court of Canada in Morgentaler v. The Queen (1975) 53 D.L.R. 2d 161 unanimously rejected the argument of

the accused that the provisions in the Criminal Code which are similar to those struck down in Bolton, infringed the Canadian Bill of Rights Act.

The American decisions just cited do not deal with minors, but they do give support to the argument that minors like adults have a right of privacy that prevents state interference with their right to medical treatment, including abortion and contraceptives. Indeed, there are already cases in state courts and lower federal courts holding invalid state laws that require parental consent to the procuring of an abortion where the person seeking it is a minor.

Doe v. Rampton (1973) 366 F. Supp. 189 (Utan)
Coe v. Gerstein (1974) 376 F. Supp. 695 (Florida)
State v. Koome (1975) 530 Pac. 2d 260 (Washington)

The only decision holding such legislation valid is Planned Parenthood v. Danforth (1975) 392 F. Supp. 1362 (Missouri).

In connection with contraception, the only case of which we are aware is Doe v. Planned Parenthood Association (1973) 510 Pac. 2d 75. The Association under contract with municipal, state and federal governments provided contraceptive information and services, but in the case of minor children required parental consent. The plaintiff was a sixteen year old girl who sought a declaration that the Association was obliged to provide her with contraceptive information without parental consent. In a 3-2 judgment the Supreme Court of Utah held that the plaintiff was not entitled to the declaration. The Supreme Court of the United States denied certiorari ((1973) 414 U.S. 805).

There is a substantial literature in connection with the minor's right to an abortion or to receive contraceptives without parental consent. The following articles

show the trend toward supporting that right.

(1) Pilpel, Minors' Right to Medical Care (1971-72), 36 Albany Law Review 462.

This article describes recent legislation in the United States that broadens the minor's right to give his own consent, and suggests a Model Act.

(2) Pilpel and Wechsler, Birth Control, Teenagers and the Law: A New Look (1971), 3 Family Planning Perspectives 37.

"It is self-evident that withholding contraceptives from sexually active persons is certain to produce unwanted babies, dangerous illegal abortions, high rates of illegitimacy and blighted young lives." Public and private programs can do little to control premarital sex but they can control unwanted pregnancies resulting from premarital sex.

This article has a chart analyzing all state laws on medical treatment of minors, and it describes the support of the AMA, ACOG, AAPed., and AAFP for permitting physicians to prescribe contraceptives to sexually active minors.

(The Hospital Law Manual, Administrators' Volume, pages 26-48 also has a state-by-state analysis of laws on the effectiveness of a minor's consent to medical treatment.)

(3) Cavanaugh, Minors and Contraceptives: The Physician's Right to Assist Unmarried Minors in California (1972), 23 Hastings Law Journal 1486.

Legislation is needed in California respecting the giving of contraceptives to minors. (Governor Reagan vetoed three bills.) Recent Supreme Court cases (Griswold and Baird) show increasing disenchantment with the notion that state regulation of contraceptives is an appropriate means of influencing the morality of individuals.

(4) Bodine, Minors and Contraceptives: A Constitutional Issue (1973), 3 Ecology Law Q. 843.

One who has reached puberty has the fundamental right of access to contraceptives. A legal requirement of parental consent does not deter premarital sexual activity.

(5) Note, Parental Consent Requirements and Privacy Rights of Minors: The Contraception Controversy (1975), 88 Harvard Law Rev. 1001.

This note considers the basic principle of Wade and Bolton (the abortion cases), namely that patients have a right of privacy that enables them to obtain medical treatments to terminate pregnancy (at least until the foetus is viable) without state intervention. Then the note asks whether this principle extends to minors who want to obtain medical care. The minors' interest must be weighed against the parents' interest in maintaining parental authority. The note concludes that the traditional family structure would not be threatened by permitting minors to give their own consent.

(6) Paul, Legal Right of Minors to Sex-Related Medical Care (1974-75), 6 Columbia Human Rights Law Review 357.

This article begins with the premise that "an unwanted pregnancy can be shattering for a teenage girl and her child." Then it describes their present legal disabilities in obtaining treatment, and goes on to mention remedial legislation. Then it argues that minors have a constitutionally protected right to sex-related medical care, without the need of parental consent.

(7) Walker, Minors and Contraceptives in Indiana (1975) 8 Indiana Law Rev. 716.

The theme of this Note is like that of the one last cited.

(8) Note, The Minor's Right to Abortion and the Requirement of Parental Consent (1974) 60 Va. Law Rev. 305.

This Note, too, makes the same point.

(9) Fraser, The Pediatric Bill of Rights (1975) 16 South Texas L.J. 245.

This article has an appendix setting out the text of all state laws on consent in relation to neglect, mature minors, emancipated minors, venereal disease, contraception, pregnancy/abortion, mental health services, drug/alcohol treatment, emergency care, and "other" matters.

(10) Wilkins, Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors [1975] Ariz. State L.J. 31.

This article discusses the common law and existing legislation and sets out a proposed Uniform Medical Consent Act.

Apart from the spate of articles on this subject, there have been statements of policy by various bodies as to the rights of the minor. We shall now note three of them.

(1) The American College of Obstetricians and Gynecologists recently published a report (undated) of its Committee on Education in Family Life. It deals with problems of sexually active minors, including their relations with parents, especially when the minor becomes pregnant. The conclusions are as follows:

1. Legal sanction should be encouraged for the minor to obtain contraception without parental consent. Direct and indirect legal barriers should be removed.

2. It is usually desirable to have parental cooperation and, in cases of the very young minor or when a pregnancy intervenes, it may be imperative.

3. If a pregnant minor refuses to involve her parents, the physician should neither refuse to help nor betray her confidence, but use his professional judgment in providing her the indicated services she needs without the parents' knowledge.

4. This decision rests entirely with the physician's judgment of a minor's responsibility and maturity. In those cases in which he may feel unsure, he should seek consultation.

5. The minor involved in sexual activity should have the right to contraceptive services, with or without parental consent. This, in turn, affords the physician an excellent opportunity to engage in sexual counseling.

(2) The American Academy of Pediatrics has prepared a Model Act providing for Consent of Minors for Health Services (1973), 51 Pediatrics, February 1973, page 293. It is rather lengthy. A pregnant minor may give consent to her treatment, and there is an elaborate provision whereby the physician may inform the parent but only with the minor's consent. The minor's power of consent does not extend to sterilization or abortion. However, "health services" include contraceptive advice and devices. A prefatory note states that the Act recognizes both the rights of the minor and of the parents, and is a compromise of those rights.

(3) The National Association of Childrens' Hospitals and Related Institutions in 1974 endorsed a Pediatric Bill of Rights as a guideline "to assure that the children and young adults of our nation are protected in their rights to receive appropriate medical care and treatment when there is conflict between the parents and the child. It is the feeling of the Board that these guidelines shall not be construed to by-pass the rights of parents unless they are in direct conflict with and not in the best interest of the child..."

The eleven canons in the Bill declare the right of every person to birth control services, treatment for venereal disease, treatment for pregnancy and abortion, psychiatric care, treatment for drug and alcohol dependency, "all in doctor-patient confidentiality". Then there is provision for emergency treatment, for consent by mature minors, and for a court order where the parents refuse to permit needed medical treatment. A useful critique of the Pediatric Bill of Rights appears in an article by Riatt, The Minor's Right to Consent to Medical Treatment: A Corollary of the Constitutional Right of Privacy (1975) 48 So. Cal. Law Rev. 1417 at 1443-1456.

In connection with the laws of each state on consent to medical treatment for minors, there is no point in setting out here a summary of all of them. We shall, however, now quote the recent legislation of seven states, to show the emerging patterns.

The first two statutes are those of Alabama and South Carolina. They do not mention contraceptives but commentators have regarded both statutes as being comprehensive.

Alabama (1971): Ala. Code, tit. 22 (Supp. 1973)

> 104(15). Any minor who is fourteen years of age or older, or has graduated from high school, or is married, or having been married is divorced, or is pregnant, may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself and the consent of no other person shall be necessary.

> 104(16). Any minor who is married, or having been married is divorced, or has borne a child may give effective consent to any legally authorized medical, dental, health or mental health services for himself, his child or for herself or her child.
>
> 104(17). Any minor may give effective consent for any legally authorized medical, health or mental health services to determine the presence of or to treat pregnancy, venereal disease, drug dependency, alcohol toxicity or any reportable disease and the consent of no other person shall be deemed necessary.
>
> 104(18). When consent not required; minors generally.--Any legally authorized medical, dental, health or mental health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life, health or mental health.

We have omitted subsections (19)-(22) as not of immediate interest. It will be noted that the general provision (subsection 15) has several alternative categories of minors who can give their own consent, and that one of these is minors fourteen years old. Subsection (16) would seem to be necessary to cover medical care for baby children of the minor. Subsection (17) is typical of several modern state laws in that <u>any</u> minor can give his own consent in connection with pregnancy, drugs, etc. Subsection (18) is an emergency provision. Nowhere is contraception specifically mentioned.

South Carolina (1972): South Carolina Code, tit. 32 Health: (1974 Cum. Supp.)

> 565. Any minor who has reached the age of sixteen years may consent to any health services from a person authorized by law to render the particular health service for himself and the consent of no other person shall be necessary unless such involves an operation which shall be performed only if such is essential to the health or life of such child in the opinion of the performing physician and a consultant physician if one is available.
>
> 566. Health services of any kind may be rendered to minors of any age without the consent of a parent or legal guardian when, in the judgment of a person authorized by law to render a particular health service, such services are deemed necessary unless such involves an operation which shall be performed only if such is essential to the health or life of such child in the opinion of the performing physician and a consultant physician if one is available.

Section 565 is comprehensive and uses sixteen years as the age of consent, except for some operations. The Attorney General gave an opinion under section 565 that "minors, sixteen years and older, are authorized by existing law to procure birth control pills without the consent of their parents or other persons." Section 566 applies to minors of any age. It covers any health service that is deemed necessary. No specific disease is mentioned, but the section is wide enough to cover almost everything.

The next two states are Maryland and Virginia. We group them together because in both states the consent provisions specifically cover contraception and no minimum age is fixed in connection with treatment for it.

Maryland (1971): Maryland Code Article 43: (1974 Cum. Supp.)

S.135.(a) A minor shall have the same capacity to consent to medical treatment as an adult if one or more of the following apply:

(1) The minor has attained the age of eighteen (18) years.

(2) The minor is married or the parent of a child.

(3) The minor seeks treatment or advice concerning venereal disease, pregnancy or contraception not amounting to sterilization.

(4) In the judgment of a physician treating a minor, the obtaining of consent of any other person would result in such delay of treatment as would adversely affect the life or health of the minor.

(5) The minor seeks treatment or advice concerning any form of drug abuse as defined in s.2 (d) of Article 43B of the Annotated Code.

S.135A.(a) A minor who has attained the age of 16 years and who has or professes to have a mental or emotional disorder may consent to diagnosis and consultation of the disorder by a physician or clinic. Consent given under this section shall have in all respects the same effect as if the minor had reached majority.

It will be noted that under section 135(a)(3) there is no minimum age in connection with venereal disease, pregnancy and contraception. We have omitted sub-paragraphs (b) and (c) of section 135: (b) protects from any liability the physician who has acted on the minor's consent and (c) permits the physician to inform the guardian, and he may do so even over the minor's objection.

In connection with pregnancy, the question is often raised as to whether "pregnancy" includes "termination of pregnancy". In Maryland this question was considered in Re Smith (1972) 295 Atl. 2d 238. A sixteen year old girl had become pregnant. She objected to an abortion, but her mother insisted on one. The Juvenile Court on a delinquency hearing directed her to obey her mother. On appeal, the Court of Special Appeals held that the act gave the girl power to consent to medical treatment concerning pregnancy, and that the court had no power to authorize the mother to override the girl's decision not to have an abortion. (Parenthetically we note that a similar problem has arisen in California on converse facts. In Ballard v. Anderson (1971) 484 P. 2d 1345, the minor wanted an abortion but a therapeutic abortion committee insisted on parental consent. A statute said that an unmarried pregnant female could give consent to medical and surgical care related to her own pregnancy. A divided judgment of the Supreme Court held that the statute applied to termination of pregnancy, so the minor could give her own consent.)

Virginia (as amended to 1974): Virginia Code Title 32 (1975 Cum. Supp.)

> S.32-137(7) Except as otherwise provided in §18.1-62.1(3) [having to do with abortions] any person under the age of eighteen years may consent to medical or health services required in case of birth control, pregnancy or family planning, or needed in the care, treatment or rehabilitation of drug addicts, or other persons who because of the use of controlled drugs are in need of medical care, treatment or rehabilitation; provided, that the provisions of this subsection shall not apply in the case of vasectomy, salpingectomy, or other surgical sterilization procedures as provided for in §32-423 of the Code of Virginia.

We have omitted the rest of section 137, which permits various public officers and others to give consent for minors and has provision for blood donations, and has an emergency provision.

The last three states are Colorado, Illinois and Tennessee. We have put them together because they all have special provisions dealing with Family Planning or Birth Control. We shall set out these provisions but not the general consent provisions.

Colorado (1971): Colorado Rev. Stats. Chapter 91 Art 1 s.38 (1971 Perm. Cum. Supp.)

> 91-1-38. Except as otherwise provided in section 40-2-50, C.R.S. 1963, [having to do with abortions] birth control procedures, supplies, and information may be furnished by physicians licensed under this article to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.

Illinois (1969): Illinois Ann. Stats. Chapter 91 s.18.7 Ann. pocket part 1975-76)

> S.18.7. Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor:
>
> 1. who is married; or
>
> 2. who is a parent; or

3. who is pregnant; or

4. who has the consent of his parent or legal guardian; or

5. as to whom the failure to provide such services would create a serious health hazard; or

6. who is referred for such services by a physician, clergyman or a planned parenthood agency.

Tennessee (1971): Tennessee Code Ann. Tit. 53 (1974 Cum. Supp.)

53-4607. Contraceptives for minors.--Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, or a parent, or married, or who has the consent of his or her parent or legal guardian, or who has been referred for such service by another physician, a clergyman, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies, or information.

The section just quoted is one of eleven that constitute the Family Planning Act of 1971. The other provisions are not of immediate interest. We might mention that the sterilization provision fixes a minimum age of eighteen years, and provides that informed consent is necessary to the operation.

APPENDIX C

Extracts from Report of the Committee on the Working of the Abortion Act, April 1974 (Cmnd. 5579)

VII. For Whom Should Contraception be Made Available?

536.(a) Married couples. No difficulty appears to arise.

(b) The unmarried. Here there is controversy, particularly concerning young people. There are strongly-held views that to make contraception available to the unmarried is to encourage sexual immorality and promiscuity and is likely to contribute to the already alarming spread of venereal or sexually-transmitted disease. While respecting such views, we are of opinion that no distinction should be made between the married and the unmarried so far as the provision of contraceptives is concerned. We are doubtful whether any substantial proportion of the unmarried population would refrain from sexual intercourse solely because of the lack of readily available contraceptives; we have evidence that most young unmarried people when they first attend a family planning clinic are already sexually experienced. For those who did not refrain the probable alternative would be unwanted pregnancies and an increased number of abortions. There may be disastrous consequences of an unwanted pregnancy to an unmarried woman and to the child if it is born, and there are the risks and disadvantages of abortion (see Sections E and F). We consider that these consequences and disadvantages are so serious that they outweigh the disadvantage of possibly encouraging or facilitating sexual intercourse outside marriage by the provision of contraceptive advice and means.

(c) Girls Under Sixteen Years of Age--see Section I.

[The relevant part of Section I is paragraphs 243-245, which we now set out.]

Contraception, Parental Consent and Confidentiality

243. A doctor's first concern is with his patient's health and in this context he may decide that contraception is indicated. Under the Family Law Reform Act 1968 (which does not extend to Scotland) a minor of 16 years may consent to his or her own medical treatment. Most doctors, if asked for advice on contraception by a patient of under 16 years, would be likely to seek her permission to consult her parents, and in our opinion, should always do so. If the girl refuses this permission, the doctor has three alternative courses open to him: he may break confidentiality with the girl in order to obtain her parents' consent to the treatment; he may refuse to continue with the treatment in the absence of consent by the parents, and so fail to give the girl the care which he considers medically necessary and leave her at risk of becoming pregnant; or he may continue with the treatment without parental consent. The last course may involve a technical assault if a vaginal examination is undertaken or an intra-uterine device is fitted; but no action has hitherto been taken against a doctor in such circumstances and we express no opinion as to whether legal or disciplinary proceedings would be likely to be successful. The doctor in each individual case has to balance his obligation of confidentiality against the desirability that, unusual circumstances apart, the parents of a child should be informed of, and agree to, the treatment given to her. This is of particular importance where a young girl has already had an abortion. The doctor may also be influenced by the knowledge that other girls may be deterred from seeking necessary medical advice if they feel that their confidence may not be respected.

244. A member of the Committee undertook an informal survey of the views of over 300 parents, a large majority of whom were against a doctor "being able to prescribe contraceptives for children under the age of consent without contacting parents". They were not however asked for their views on the position where a doctor, having tried and failed to obtain the girl's consent to her parents being consulted, is of opinion that she will have sexual intercourse without contraceptive measures unless he provides them.

245. There were differing views amongst members of the Committee on the problem of informing parents. A majority of members believe that in exceptional cases doctors should make contraception available without the knowledge or consent of the parents where the girl has refused to consent to their being told, on the ground that in such cases this may be a lesser evil than allowing the girl to run the risk of pregnancy.

APPENDIX D

The Emergency Medical Aid Amendment Act, 1974

The following section is added after section 3:

4. Where an adult person

(a) is, in the written opinion of two physicians, in need of an examination or medical, surgical or obstetrical treatment or is, in the written opinion of two dentists in need of dental treatment,

(b) is incapable by reason of mental or physical disability of understanding and consenting to the examination or medical, surgical, obstetrical or dental treatment needed, and

(c) has not previously withheld consent to the examination or medical, surgical, obstetrical or dental treatment needed, to the knowledge of either of the physicians or the dentists referred to in clause (a),

a physician or dentist may, without the consent of any person,

(d) examine the person,

(e) prescribe treatment for the person, and

(f) provide the person with such medical, surgical or obstetrical treatment or with such dental treatment, as the case may be,

in such a manner and to such an extent as is reasonably necessary and in the best interests of the person examined or treated, in the same way that the physician or dentist could have acted if the person had been an adult of full legal capacity and had consented to such examination or treatment.

APPENDIX E

MINORS' CONSENT TO HEALTH CARE ACT

1. In this Act "health care" means treatment by a qualified medical or dental practitioner in the course of his practise, and includes mental and surgical care, prevention and diagnosis of disease or ailment, the administration of anesthetics, procedures for the purpose of preventing pregnancy, and treatment given by any person pursuant to directions given in the course of practise by a qualified medical or dental practitioner, but does not include surgical sterilization.

(Recommendation #9 and
Recommendation #6)

2. (1) The law respecting consent to health care of persons who have attained the age of majority applies, in all respects, to minors who have attained the age of sixteen years in the same manner as if they had attained the age of majority.

(Recommendation #1,
Uniform s. 2)

(2) A consent to health care given by a person who has not attained the age of sixteen years of age is valid if the medical or dental practitioner had no reason to believe that the person who gave it had not attained the age of sixteen years.

(Recommendation #7)

3. (1) A minor of any age may consent to health care in connection with any communicable disease as defined in The Public Health Act, drug or alcohol abuse, prevention of pregnancy, and pregnancy and its termination.

(2) Where the minor is under the age of sixteen years his power to consent pursuant to this section does not exclude the power to consent of a parent or guardian.

(Recommendation #2)

4. A minor who has borne a child may consent to health care for herself and her child.

(Recommendation #3)

5. (1) Where the consent of a parent or guardian to medical treatment of a minor is required by law and is refused or otherwise not obtainable, any person may apply to the Supreme Court for an order dispensing with the consent.

(2) The court shall hear the application in a summary manner and may proceed ex parte or otherwise and, where it is satisfied that the withholding of the medical treatment would endanger the life or seriously impair the health of the minor, may by order dispense with the consent of the parent or guardian to such medical treatment as is specified in the order.

(Recommendation #5,
Uniform s. 4)

(3) No application shall be made pursuant to this section in the case of a minor under the age of sixteen years who has been apprehended under section 16 of the Child Welfare Act.

(Recommendation #5)

6. Nothing in this Act affects the law relating to the administration of health care in emergencies.

(Recommendation #4)

7. Where a minor has consented to health care pursuant to this Act, patient-physician confidentiality shall apply.

(Recommendation #8)

NOTE: An amendment to the Child Welfare Act will be needed to give effect to Recommendation #5(3).

APPENDIX F

ACKNOWLEDGMENTS

1. M. Nora Clark, Member, Provincial Family Planning Co-ordinating Committee, Calgary, Alberta.

2. Robert Clark, M.D., Executive Director, Alberta Medical Association, Edmonton, Alberta.

3. Patricia Dalenger, Member, Provincial Family Planning Co-ordinating Committee, Edmonton, Alberta.

4. Beryl Ebert, Chairman, Provincial Family Planning Co-ordinating Committee, Edmonton, Alberta.

5. David J. Hosking, M.D., Medical Officer of Health, Calgary, Alberta.

6. Wendy Klassen, Co-director, Birth Control and Information Centre, Lethbridge, Alberta.

7. Rosalee Lewis, Member, Provincial Family Planning Co-ordinating Committee, Edmonton, Alberta.

8. J. Herbert Presley, Member, Provincial Family Planning Co-ordinating Committee, Edmonton, Alberta.

9. John G. Read, M.D., Assistant Executive Director, Medical Services, University of Alberta Hospital, Edmonton, Alberta.

10. Patricia Rice, Administrative Assistant, Social Services Department, Calgary, Alberta.

11. Anne Russell, Director of Legal Services, Department of Social Services and Community Health, Edmonton, Alberta.

12. B. M. Strehler, Executive Director, Family Planning Federation of Canada, Toronto, Ontario.

13. D. K. Wass, Superintendent, Edmonton Social Services, Edmonton, Alberta.

14. R. W. Winter, M.D., President, Alberta Society of Obstetricians and Gynecologists, Edmonton, Alberta.

15. J. Ross Vant, M.D., Edmonton, Alberta.