CONSENT OF MINORS TO MEDICAL TREATMENT

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TABLE OF CONTENTS

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I

INTRODUCTION

The problem to be discussed in this research paper is the legal capacity of the minor to validly consent to medical treatment. It is a complex problem, because of the legal, social, moral and religious aspects involved, but also because it concerns the interests of three different parties, the medical profession, the minor and the parents of the minor.

The study of this problem is undertaken upon a request by the first Family Planning Conference in Alberta, held in May, 1973, which request reached the Institute via the Department of Preventive Social Services of the City of Edmonton. The Institute was asked in particular "to investigate the legal pressures limiting the prescribing of contraceptives for girls under the age of 18 without parental consent."

The College of Physicians and Surgeons in Alberta also approached the Institute and urged legislation in this field. At the present time there is no Alberta statute dealing with age of consent for medical treatment. The medical profession is concerned about which rules to follow while treating minors. This concern is underlined by the action that was recently brought against the Edmonton School Board and the City of Edmonton and the Edmonton Board of Health in connection with the prescribing of contraceptives to a sixteen year old school girl.

Apart from the physicians' concern about the fact that their legal position with regard to medical treatment of minor's is not clear at all, doubts are being expressed about the age of majority as the age of consent to medical treatment. It has been called unrealistic that teenagers, who know quite well what they want and who live independent from their parents, still need parental consent in cases of medical treatment.

To outline the extent of the research it is necessary to explain first what the terms "minor", "consent" and "medical treatment" encompass.

II

WHO IS A MINOR?

The age of majority is, in most of the Canadian provinces, 18 years.[1] In the provinces of Newfoundland, New Brunswick, Nova Scotia and British Columbia it is 19 years.[2] Upon reaching the age of majority a person is legally competent to enter into a binding contract. He does not need an agent to act for him, neither is parental authority necessary

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[1] See The Age of Majority Act, S.A. 1971, C.1 S.1; The Age of Majority Act, S.M. 1970, C 91 S. 1(1): The Age of Majority and Accountability Act, 1971, S.). 1971, c. 98 s. 1; Civil Code P.G. Art. 246; The Age of Majority Act, S.P.E.I. 1972, C. 2, S. 1(1).

[2] The Minors (Attainment of Majority) Act, 1971, S.N. 1971, No. 71, S. 6(1); Age of Majority Act S.N.B. 1972, C.5, S. 1(1); Age of Majority Act, S.N.S. 1970-71, C. 10, S. 2(1); Age of Majority Act, S.B.C. 1970, C. 2, S. 2(1)(a).

to make his acts valid. As a result, in Alberta, a person 18 years of age or over may give a valid consent being necessary.[3]

The question is whether the age of majority also must be considered as a standard for consent to medical treatment and whether parental consent is necessary for a person under 18 years old. It is clear that a new born child is incapable of consenting to his own medical treatment. Krever says:

> The real problem is whether there is an age between the neonatal condition and the age of 18 when parental consent is not necessary and the child's own consent is a sufficient authorization for medical treatment. There is no clear answer to this question. In the absence of a statutory answer and, in my opinion, there is none, we are thrown back to the common law, or the decisions of the courts and here certainty is not possible.[4]

The Report of the Committee on the Age of Majority presented to the Parliament of the United Kingdom by the Lord Chancellor in July, 1967, and known as the Latey Report, says about the problem mentioned by Krever:

> 479. The legal position is in itself obscure. A cause of action to which a hospital authority or a

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[3] An interesting question is whether the relationship between physician and patient can be considered as one resulting out of contract. In Holland the relation physician-patient is governed by the rules of contract.

[4] Horace Krever, Q.C., "Minors and Consent for Medical Treatment", Lecture delivered at the University of Toronto, March 18, 1974.

> member of its medical staff (or both) may be liable as the result of the performance of an operation is trespass to the person, and treatment administered without the patient's express or implied consent constitutes an assault which may lead to an action for damages. Until recent years the general rule has been to require the consent of a parent or guardian for an operation or an anaesthetic on a person under 21, but increasingly at the present time it is becoming customary to accept the consent of minors aged 16 and over. There is no rigid rule of English law which renders a minor incapable of giving his consent to an operation but there seems to be no direct judicial authority establishing that the consent of such a person is valid.[5]

In a recent article in the Modern Law Review, Skegg pointed out that:

> Opinions on the common law capacity of minors to consent to medical procedures fall into three broad categories: that all minors are by reason of their age incapable of giving a legally effective consent; that all minors under some "age of consent," invariably sixteen, are by reason of their age incapable of giving a legally effective consent; and that no minor is incapable by reason of his age alone, but that it

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[5]London, Her Majesty's Stationery Office 1967 Cmnd. 3342, par. 479.

> all depends on his capacity to understand and come to a decision on the procedure in question.[6]

The opinion that the common law does not fix any age, below which minors are automatically incapable of consenting to medical procedures is supported by Skegg and others.

Lord Nathan says in his classic work on medical negligence:

> . . .[A]n infant who is capable of appreciating fully the nature and consequences of a particular operation or of particular treatment can give an effective consent thereto, and in such cases the consent of the guardian is unnecessary;. . .It may, however, be necessary to add to the proposition suggested above the rider that a surgeon or physician will, in any event, only be able to rely upon the infant's consent as a defence where he performed the operation or administered the treatment *bone fide* in the interests of the infant's own health.[7]

A few years later W.F. Bowker suggested three rules with respect to the consent of a minor to medical treatment:

> The requirement of consent to therapy for the minor can be described as follows:
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> 1. Where he is mature and has left

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[6]P.D.G. Skegg, "Consent to Medical Procedures on Minors", (1973) 36 M.L.R. 370.

[7]Lord Nathan, Medical Negligence 1957, 176-177.

> home, he can give his own consent, just as an adult can;
>
> 2. Where he is mature and living at home, the position is the same as in 1;
>
> 3. Where he is "of tender years" the guardian's consent is necessary.[8]

In two recent articles the opinion that the mature minor can give valid consent to medical treatment is confirmed. Bowker states: ". . .the common law of England and Canada permits a minor approaching majority to give his own consent."[9]

> Judicial response to the harshness of a requirement of parental consent for all medical care to minors has come largely through development of what is widely labeled the "mature minor" rule. The effect of this rule is to allow a subjective appraisal of at lease some cases in which physicians proceed with non-emergency medical care for minors with only the patient's consent.[10]

The mature minor rule is supported in two significant cases. The first case is *Booth v. Toronto General Hospital*.[11] In this case a youth 19 years of age, who was earning his own living, was held to be capable of consenting

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[8] W.F. Bowker, "Legal Liability to Volunteers in Testing New Drugs", 1963, 38 Can. Med. Assoc. J., 745-749.

[9] W.F. Bowker, "Experimentation on Humans and Gifts of Tissue: Articles 20-23 of the Quebec Civil Code", McGill Law Journal, Vol. 19, n9. 2, 1973.

[10] Wadlington, "Minors and Health Care: The Age of Consent" (1973) 11-1 Osgoode Hall Law Journal, 115.

[11] (1910) 17 O.W.R. 118 per Falconbridge C.J.K.B.

to a throat operation, beneficial to his health. In the second case, *Johnston v. Wellesley Hospital*[12] no parental consent had been obtained for non-emergency treatment of a 20-year old male[13] to remove facial marks caused by acne. The claimant asserted both negligence and invasion of his body without appropriate consent. As to the latter claim, Addy J. of the Ontario High Court pointed out that:

> It is not the law of Ontario that a person of 20 years of age, who is obviously intelligent and as fully capable of understanding the procedure as an adult, is incapable of consenting thereto and that, in such a case, the absence of parental consent renders the treatment an actionable assault, even where there is no question of emergency treatment. The consent of the parent or guardian is unnecessary provided the consent of such an infant is a fully-informed consent.

The court expressly approved Lord Nathan's view of the law.[14]

The "mature minor" rule has also been adopted in the U.S., sometimes by statute.[15] One significant case is *Lacey v. Laird*,[16] in which case it was held that an 18-year old girl (a minor under Ohio law) could consent to a simple operation involving plastic surgery on her nose. Another

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[12](1970), 17 D.L.R. (3d) 139.

[13]The age of majority in Ontario was at the time of the decision, still 21.

[14]*Supra*, p. 5.

[15]See Chapter V, Survey of American State Legislation p. 53-69.

[16]166 Ohio St. 12, 139 N.E. 2d 25 (1956).

case is *Younts v. St. Francis Hospital and School of Nursing, Inc.*,[17] in which the Supreme Court of Kansas was asked to hold that taking a skin graft from the forearm of a 17-year old girl to repair her injured finger was battery, because the surgeon had not first secured parental consent. It was an emergency situation and neither of the parents were immediately available to give consent. The court denied recovery, not because of the emergency situation, but it held that given the particular circumstances this 17-year old

> . . .was mature enough to understand the nature and consequences and to knowingly consent to the beneficial surgical procedure made necessary by the accident.[18]

We may assume that the common law establishes the "mature minor" rule with regard to valid consent by minors to medical treatment. The rule says that a minor can give effective consent to medical treatment, where he fully understands its nature and consequences.

III

CONSENT

Wadlington states in his article:[19]

> The law of torts protects us against unauthorized invasions of our bodies. Medical treatment without consent thus becomes a trespass--what some

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[17] (1970), 205 Kan. 292, 469 P 2d 330 (S.C.).

[18] *Supra*, not 16.

[19] *Supra*, note 9.

> courts have termed a "technical battery.[20]

Krevers opinion is that:

> The concept of our law is based on the premise of the integrity and inviolability of the person in our society. Historically, and intentional interference with the body of another person, technically known as a battery, but more often, even among lawyers, called an assault. Every intentional touching, then is *prima facie*, to use lawyers' jargon, actionable, that is to say, is an act exposing the toucher to liability in damages, and puts him in the position, if he is to avoid such liability, of being required to justify his act of touching.[21]

The law does not deal specifically with intentional touching by physicians.

> Surgical operations are not in a different category from other medical procedures, nor are medical procedures in a different category from other applications of force.[22]

Thus to avoid legal liability for battery or trespass[23] physicians have to justify their intentional interference with another's person.

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[20]"A surgical operation on the body of a person is a technical battery or trespass, regardless of its results, unless the person or some authorized person consents to it", see *Supra*, note 16.

[21]*Supra*, note 3.

[22]Devlin P., Samples of Law Making, London, Oxford University Press (1962) pp. 84-85.

[23]The subject of liability of physicians and surgeons will be dealt with in Chapter VI.

We may assume that in general a valid consent is sufficient justification for this interference.[24]

Horace Krever states:

> The issue therefore becomes one of determining what the criteria are for a valid consent. For our purposes they are two in number: (a) an understanding on the part of the person consenting of the nature and effect, including generally, the risks, of the procedure consented to, or, in other words, "informed consent", and (b) legal competence to give the consent.[25]

1. Informed Consent

As to informed consent: the question is in case of minors, how to know that the minor really understands the nature, effect and risks of a medical treatment.

Skegg says in his article:

> There is obviously room for considerable difference of opinion as to whether a particular child was capable of understanding, and did in fact understand, what was involved in a particular procedure. This makes it especially important for the doctor to ensure that the child fully understands all the relevant considerations. The courts are unlikely to question the capacity of a normal seventeen-year-old to consent to the removal of blood for transfusion, but they are likely to be much more wary with, for

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[24] See for the question whether a consent to treatment not in the benefit of the patient can validly be given and constitutes justification for interference Chapter VII at p. 107 etc.

[25] *Supra*, note 3.

> example, a fourteen-year-old who purports to consent to the removal of one of his kidneys, for transplantation to his twin brother. Nevertheless, it is submitted that many fourteen-year-old children are capable of consenting to such an operation. On two occasions, American courts have found that children of that age fully understood the nature of a nephrectomy and its possible consequences, and freely consented to it. From the doctor's point of view, the danger is that, in the unlikely event of proceedings being brought, a judge or jury who disapproved of the removal on moral grounds would hold, without making any proper examination of the minor's intellectual capacity, that he was in fact incapable of consenting.[26]

In this regard it is important to examine the possibility that there is or should be a provision whereby minors cannot effectively consent to medical procedures which are to their detriment. We will come back to this in a later Chapter.

From the other side there is the question how far the physician has to go in explaining the risks of a specific medical procedure to a patient. Is it necessary that the physician explains all the risks which could possibly evolve out of the medical procedure even though these risks might be far removed?

Is it sufficient that the physician only mentions

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[26] *Supra*, note 5.

the risks, which are most likely to happen? What about the situation in which a physician for instance is more or less convinced that upon explaining all the risks the patient would refuse a certain treatment or operation, although it would be to his benefit?

Bowker states about this specific problem:[27]

> When a physician advises his patient posed treatment, must he disclose the risks, so that if he fails so to do, the consent will be ineffective and the patient can say that the physician acted without consent? The physician or surgeon must explain the risks to enable the patient to exercise an intelligent judgment on whether to elect to proceed. In Canada the few cases dealing with this subject allow the physician a wide scope in exercising his judgment, bearing in mind the desirability of not upsetting the patient. The two leading cases are from the Ontario Court of Appeal. In *Kenny v. Lockwood*[28] it was argued that the surgeon had not explained the risk of stiffness resulting from an operation on the hand. A prominent surgeon, Dr. Gallie, testifying as an expert witness, said that if he outlined every risk, including remote ones, some of which were rather frightening, the patients would decline the operation and would damage themselves by waiting to see what would happen without the operation. The court held that the defendants were not liable for failure to dis-

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[27] *Supra*, note 8.

[28] *Kenny v. Lockwood* (1932), O.R. 141, (1932), 1 D. L.R. 507. See also, *supra*, Lord Nathan, note 6, pp. 48-57.

close the risks. In the second case, *Male v. Hopmans*,[29] the patient was treated with neomycin although it was known that this drug could affect the hearing. The patient did in fact become deaf. One of his allegations of negligence was that the defendant had failed to disclose this risk. The alternative treatments were very complicated and the court held that the defendant was under no duty to explain them. It was said that the patient probably could not have grasped the explanation or made an intelligent choice.

In an English case, *Hatcher v. Black*[30] the operation was for a toxic goitre. There was in fact a risk to the voice, and the surgeon admitted that he had told the patient that there was no risk. In summing up to the jury, Denning L.J. (as he then was) directed the jury that the little white lie was justifiable. This decision is not consistent with the view of New Zealand Court of Appeal in *Smith v. Auckland Hospital Board*,[31] in that case the patient specifically asked the surgeon whether there was any risk in a diagnostic procedure called aortography. The surgeon replied that there was none. In fact there was a known risk of loss of circulation which could cause gangrene in a leg and require amputation. This risk materialized. The court found a breach of duty. The difficulty was whether the untruthful answer caused the loss of the leg, for one can only conjecture whether the patient would have rejected the procedure had he been told the truth.

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[29] See *Male v. Hopmans* (1966), 54 D.L.R. (2d) 592, and on appeal (1967), 64 D.L.R. (2d) 105, 113. The defendant was held liable on another ground.

[30] *The Times*, July 2, 1954: quoted in Nathan, Medical Negligence (1957) 54.

[31] [1965] N.Z.L.R. 191, rev'g [1964] N.Z.L.R. 241.

> The court held that there was evidence on which the jury could find a causal connection between the answer and the loss of the leg.
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> There has been a difference of opinion on whether, assuming an absence of informed consent, the patient's action is based on negligence or assault. In the *Smith* case the claim was based on negligence. It is submitted that this is the proper basis, though some courts take the view that an uninformed consent is no consent, with the result that the operation is an assault.[32]

In the United States the jurisprudence around the issue of informed consent is extensive. The trend is towards a greater disclosure of the risks involved in medical treatment. The reason behind the greater disclosure is that every human being has the right to determine what will be done with his own body and to exercise his freedom of choice in evaluating the risks of the proposed and alternative treatment.

Two recent and most significant cases on informed consent in the U.S. are *Canterbury v. Spence*[33] and *Cobbs v. Grant*.[34]

In *Canterbury v. Spence* the United States Court of Appeals, District of Columbia Circuit decided:

> A physician is under an obligation to

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[32] Plante, "An Analysis of 'Informed Consent'", (1967-68) 36 Fordham L. Rev. 639. See also Chapter V at p. 75 etc.

[33] 464 F. 2d 772 (D.C. Cir. 1972).

[34] 502 P. 2d 1.

> communicate specific information to his patient when exigencies of reasonable care call for it, and due care may require a physician perceiving symptoms of bodily abnormality to alert his patient to that condition.[35] Due care may also require a physician to advise his patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued and also demands that a physician warn his patient of any risks to his well being that the contemplated therapy involves.[36] The patient must have some familiarity with the therapeutic alternatives and their hazards in order to make his decision.
>
> . . .a reasonable explanation means that the patient must be generally informed in non-technical terms as to what is at stake.[37] A physician cannot ordinarily obtain valid consent from a patient for treatment without first elucidating the options and perils for the patient's edification. This duty to inform is not dependant upon a patient's request for disclosure.[38]

The *Canterbury* case was followed by the decision of the Supreme Court of California in *Cobbs v. Grant*. Both cases are discussed in the Houston Law Review[39] and the article appeared as Chapter IX, Informed Consent, in a study called *The Law of Texas Medical Malpractice by Jim Perdue*.

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[35] See *supra*, note 30, at 781.

[36] *Id.*

[37] *Id.* at 782, note 27.

[38] *Id.* at 783, note 36.

[39] (1974) Vol. II 1075.

In *Cobbs v. Grant* the court held

> . . .that as an integral part of the physician's overall obligation to his patient, there is a duty of reasonable disclosure of available choices with respect to the proposed thereapy and of the dangers inherently involved in each. The patient should not be denied an opportunity to weigh the risks of surgery or other treatment unless it is evident that he cannot evaluate the date, such as in the case of an emergency or if the patient is a child or incompetent.[40]

With regard to the reasonableness of the disclosure the majority of courts have often related the duty to the custom of physicians practicing in community. On the other hand in *Cobbs v. Grant* it was held that:

> Respect for the patient's right of self determination on particular therapy demands a standard set by-law for physicians rather then one which physicians may or may not impose upon themselves.[41]

The court stated that "the scope of the disclosure required of physicians, defies simpler definition"[42] and

> The patient need not be given a lengthy polysyallabic discourse on all possible complications. A mini-course in medical science is not required. The physician is not under a duty to discuss relatively minor risks inherent in common procedures when it is common knowledge that such risks inherent in the procedure are of

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[40] See *supra*, note 33 at 10.

[41] *Id.* at 10.

[42] *Id.* at 10.

> of very low incidence.[43] When the given procedure involves a known risk of death or serious bodily harm, however, the doctor has a duty to disclose to the patient the potential of death or serious harm and to explain in lay terms the complications which might possibly occur.[44]

Both cases may have significant importance for the future development of the doctrine of informed consent. The decisions favour the right of self determination of the patient above the age-old adage "doctor knows best". They force physicians to be more communicative and informative, although the guidelines as to the extent of the information give the physician enough latitude to gear what he tells to the material needs of the patient.[45]

The question is whether the full disclosure by physicians should be applied in cases where the medical treatment concerns minors. In *Canterbury v. Spence* and in *Cobbs v. Grant* is expressly stated that "A person of adult years and sound in mind has the right, in the exercise of control over his own body to determine whether or not to submit to lawful medical treatment."

Should the "mature minor" be included in the category of persons of adult years?

In *Cobbs v. Grant* it is held that:

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[43] *Id.* at 11.

[44] *Id.* at 11.

[45] See also article by Jim Perdue in Houston Law Review mentioned in note 38.

> A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent. . .and if the patient is a minor or incompetent, the authority to consent is transferred to the patient's legal guardian or closest available relative.[46]

The above phrase seems to expressly exclude minors from all the people, who are able to give informed consent. The use of the terms 'child' and 'minor' in the same context is confusing, especially because California allows minors, in certain cases, to give their own consent to medical treatment.[47]

We may assume that in Canada the "mature minor" rule is in force[48] and this rule may be seriously affected if Canada should follow the U.S. trend, that full disclosure of risks is required before informed consent can be assumed. Because in that case it could be hard to prove that a minor was capable of understanding the nature, consequences and risks of a certain treatment.

The matter of informed consent is therefore certainly a matter that we have to deal with, if we are goint to draft a statute for Alberta providing possibility for minors to consent to their medical treatment. Wadlington is of the same opinion. He states:

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[46] *Supra*, note 33 at 10.

[47] Calif. Civ. Code, §346. (Curr. Supp. 1972).

[48] See *Supra*, p. 8.

An even more serious problem is the extent to which the statutes have failed to deal with the requirement of an "informed" consent. Although a detailed discussion of this concept and questions such as whether failure to adequately inform a patient of risks attendant to a particular treatment or operation should be deemed a battery or negligence is beyond the scope of this comment, we must not overlook the serious ramifications which the informed consent requirement can have when the patient is a minor. Let us assume that a legislature has lowered the age of consent for medical treatment to 12. Are we certain that even the majority of 12-year-olds can comprehend and assess the risks involved in most medical treatment? Must there be a special child's version of the explanation of proposed medical procedures and their potential meaning for the patient? Although some consent statutes contain no age floor, surely there must be some level at which the physician should be placed in the position of questioning individual patient competence to consent because of youth. In short, even under the broader of today's statutes some subjective evaluation by the physician probably will be necessary, and some judicial interpretation may be required of statutes in which this was not anticipated. The question ultimately becomes one of how much discretion we wish to posit in the medical profession, and not just with the minor patient. This raises the concern of possible physician overreaching in the extension of unnecessary or undesirable medical services to minors. At the moment this does not seem to be considered a threat, and the principal emphasis is on enabling minors to get to physicians who will be able to treat them without fear of civil liability except in instances of negligence.[49]

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[49] See *Supra*, note 9.

2. Legal Competence

Above[50] we stated that there are two criteria for a valid consent. One was informed consent, the other was the legal competence to give the consent. The incompetency to consent may be the result of mental incompetency or lack of legal capacity for other reasons such as non-age.

For a discussion of the latter problem we refer to Chapter II, where we saw that there is no rigid rule in the common law, which renders a minor incapable of consenting to medical treatment[51] and where we explained the development of the "mature minor" rule.[52]

In the scope of this research it is not necessary to deal with the lack of legal capacity to consent resulting out of mental incompetence.

IV

MEDICAL TREATMENT

In the foregoing chapters we have been talking about a minor's consent to medical treatment without confining the meaning of medical treatment.

The literature consulted in the previous chapters does not specify the term medical treatment. From the medical dictionaries which I looked up, only one gave a definition of

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[50] *Supra*, p. 10.

[51] *Supra*, p. 4.

[52] *Supra*, p. 5 etc.

treatment.[53] Treatment is: "the care of a sick person and the remedies or means employed to combat the disease affecting him." Assuming that in common law the mature minor generally is capable of consenting to medical treatment, the mature minor would, in case the above definition of medical treatment is applicable, not be able to consent to the prescription of oral contraceptives has no therapeutic value.

As one of the purposes of this study is to examine the possibility for minors to get contraceptive services without parental consent, the above definition is of no help. We certainly need a broader one, which covers contraceptives as well.

Some statutes dealing with consent of minors to medical treatment paraphrase the term medical treatment.

Section 8(2) of the English Family Law Reform Act 1969 says:

> 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.

British Columbia gives the same paraphrase in section 23 of the Infants Act.[54] The B.C. provision only goes

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[53] Bernard S. Maloy M.D., Medical Dictionary for Lawyers 3d ed., Illinois [1960].

[54] The Infants Act, R.S.B.C. 1960, c. 193, as amended in S.B.C. 1973, c. 43, s. 23(2).

further by identifying those persons, who are qualified to give "surgical, medical, or mental treatment and dental treatment.

In Ontario the matter of consent to minors to medical treatment is dealt with in Regulation 729 under the Public Hospitals Act.[55] Regulation 729 was changed in 1974[56] and provided that consent in writing should be obtained before a "surgical operation" (see s. 49) and before a "diagnostic test or a medical treatment procedure" (see s. 49(a)).

Quebec says in section 36 of La loi de la protection de la Santé publique:[57]

> An establishment or a physician may provide the care and treatment required by the state of health of a minor. . .

The report of the Ontario Commissioners for the 1973 Conference on Uniformity of Legislation in Canada contains a draft Medical Consent of Minors Act. Section 1 of this Act deals with interpretation and says:

> In this Act, "medical treatment" includes surgical and dental treatment and any procedure undertaken for the purpose of diagnosis and includes any procedure that is ancillary to any treatment as it applies to that treatment.

None of the above paraphrases is clear enough to

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[55]The Public Hospitals Act, R.S.O. 1970, c. 378.

[56]O. Reg. 100/74. (The Ontario Gazette, March 9, 1974, p. 122).

[57]Loi de la protection de la santé publique, L.Q., 1972 c. 42 entree en viqueur le 28 fevier 1973.

make sure that the prescription of oral contraceptives is included, except may be for the Quebec one, which mentions care and treatment (not in general) required by the state of health of the minor. We can assume that a physician in prescribing contraceptives to a minor exercises due care of preventing the minor from becoming exposed to the risks of pregnancy.

The Alberta Commissioners for the Conference on Uniformity of Legislation in Alberta even filed their disapproval with the proposed draft "Medical Consent of Minors" Act, one of the reasons being that:

> We are not satisfied that the definition of "medical treatment" in section 1 is adequate. It refers only to "treatment" may not extend to an examination of a patient made prior to treatment nor to procedures that are in their nature preventative only, such as the prescribing or implantation of a contraceptive device in a minor female and an abortion performed on minor female. The definition may not extend to some purely diagnostic procedures that involve the use of apparatus in circumstances that might be said to involve a medical battery. We appreciate that the definition of medical treatment follows the one in the English Act, and that the Ontario Commissioners were not empowered to change it in the absence of instructions from the Minaki meeting. However, we feel that these points should not be left in doubt, and that the definition could be reqritten to put them beyond doubt.[58]

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[58] See a letter by Glen Acorn of Nov. 27, 1974, on behalf of the Alberta Commissioners to Mr. Robert C. Smethurst, then Secretary of the Conference of Commissioners.

The fact that there is some confusion about what is meant by medical treatment emphasizes the need to deal with this matter in an Act if Alberta decides to get an Act on Consent of Minors for Medical Treatment.

A lot of the American statutes mention instead of the term "medical treatment", "medical or health services" or "medical care",[59] which terms in my opinion cover the whole scheme from counseling, prevention and diagnostic procedures to treatment and surgery.

A second caveat we have to pose upon the term 'medical treatment' is: does the term 'medical treatment' include experimental therapy and if it does, should minors be capable to give valid consent to experimental therapy.

Bowker distinguishes in his article[60] between experimental therapy and scientific experiment:

> Experimental therapy is a new procedure in the prevention, diagnosis of treatment of disease. It may of course provide important information as well and thus have an aspect of research. However its immediate purpose is the good of the patient.
>
> Scientific experiment on humans can be defined as something done to the person with the principal purpose of finding out what will happen to the person. Its primary object is the ac-

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[59] See the survey in Albany Law Review 1971-72, Vol. 36, pp. 472-487, as appendix to Harriet F. Pilpel, Minors Rights to Medical Care.

[60] See *Supra*, note 8.

> quisition of new knowledge rahter than therapy, and the fact that ultimately it may prove to be beneficial to others or even to the subject does not render it therapy.

As to our research object in "consent of minors to medical treatment", we don't have to consider scientific experimentation, because this is not a form of medical treatment.

However experimental therapy is relevant and the question is whether we must allow minors to consent to experimental treatment, although there is probably more risk involved than in an established treatment, and a second question is "what is the liability of a physician to his patient when the patient is harmed because the doctor in the hope of benefiting the patient has used an experimental procedure--one that is new or at least not generally accepted?"[61]

We may assume that the liability of a physician in therapeutical experiments is not different from the liability in non experimental medical procedure.[62] As long as the physician exerts proper care in performing the procedure and he has a valid consent, he will not likely be held liable. We have to note however that the physician must be extra careful with regard to the requirement of the consent.

Under Canadian law a mature minor may consent to

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[61] See *Supra*, note 8, p. 166.

[62] See Chapter VI. . .

the risk of injury.[63] In case of experimental therapy there is good reason to require that the consent is fully informed although the common law in Canada allows the physician a wide scope of discretion with regard to disclosure of risks. Analogously as to scientific experimentation, as explained by Bowker,[64] consent of minors to experimental therapy should, in my opinion, only be possible provided that the "risk assumed is not disproportionate to benefit anticipated" or "that no serious risk to his health results therefrom".[65]

The British Medical Research Council advocates obtaining of parental consent in cases of experimental therapy and scientific research, although it does not make it a legal requirement:

> Even when true consent has been given by a minor. . .considerations of ethics and prudence still require that, if possible, the assent of parents, guardians or relatives, as the case may be, should be obtained.[66]

In the United States the following suggestion is made regarding the legal and ethical standards for experimental therapy involving children:

> Where the research is therapeutic in nature, i.e., where the minor is a patient and the study is intended to

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[63] See *Supra*, note 7.

[64] See *Supra*, 8, p. 166 and 167.

[65] See article 20 of the Quebec Civil Code.

[66] Responsibility in Investigations on Human Subjects, Medical Research Council Great Britian, 1968.

> benefit him in the relief of his present clinical condition, or where the study is intended to add to knowledge about his present condition, then a minor of any age may be included in the study as long as informed consent is obtained from the minor's parents or guardian. Studies which are therapeutic in nature are generally defined in the regulations of the Federal Food and Drug Administration. The concept of "informed consent" is adequately discussed elsewhere and is now generally accepted by reputable investigators as an ethical and legal standard of primary importance. It is admitted that the nature of *informed* consent (giving full information on the risks and benefits reasonably to be expected) and the complexities often surrounding its attainment are such that sometimes it becomes only a goal toward which we strive. In any case, it is clear that informed consent requires that the parents be apprised of the experimental nature of the procedure, distinguishing it from the assumed treatment being received by the patient-subject-child who is involved.[67]

Concluding we can say that experimental therapy takes a specific place within the whole field of medical treatment and that because of the nature and possible consequences of experiments a special protection in case of experiments on minors is justified. The special protection might exist in:

1) the requirement of absence of serious risks to the health of the minor;

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[67] William J. Curran J.D., S.M. Hyg and Henry K. Beecher, M.D., "Experimentation in Children", The Journal of the American Medical Association, [1969] Vol. 10, No. 1, pp. 77-83.

2) the requirement of parental consent in all cases of experimental nature;

3) both of the requirements mentioned in 1) and 2);

4) in a "no experiment rule" with regard to minors.

As to the last suggestion: Bowker states in his article:

> In the common law there is no automatic liability;[68] in other words there is not a "no-experiment" rule. In the United States on the other hand there was such a rule for a long time but it has been eroded. The argument in favour of it is that it discourages reckless experimentation. The argument against it is that it deters progress. A middle ground is to permit it in the sense of not rendering the physician automatically liable if something goes wrong, but to require a high degree of care and also disclosure to the patient of the fact that the treatment is new and risky. . .In my opinion this "middle ground" presents the common law position.[69]

V

LEGISLATION DEALING WITH THE PROBLEM OF MINORS CONSENT TO MEDICAL TREATMENT

1. England

It is appropriate to discuss first the situation in England with regard to legislation dealing with Minors Consent to Medical Treatment, because a lot of the developments

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[68] He refers to the liability of physicians in cases where they use experimental procedures on patients.

[69] See *Supra*, note 8.

in Canada are based on the English solution to this problem.

Legislation on this subject is to be found in section 8 of the Family Law Reform Act 1969, which is an implementation of the recommendations of the Latey Committee.[70]

Section 8 of that Act reads as follows:

> 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 purpose 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.

The English provision leaves no doubt as to the minors capacity to consent, when he is sixteen years or older. His consent is "as effective as it would be if he were of full age". The section makes it also clear that the consent

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[70] See *Supra*, note 4, p. 4.

of a person of sixteen or seventeen can be relied on by a doctor as a defence to an action in trespass by that person; the doctor does not have to seek the consent of any other person. Consequently if a minor has given his consent to treatment the parent does not have a cause of action against the doctor on the ground that his consent has not been obtained.

The question is what happens if the minor refuses to give consent and the parent consents. Is the parent consent effective as a defense to an action in trespass by the minor against the doctor who carried out the treatment?

In a comment on the English provisions[71] David Foulkes says with regard to this question:

> It has been suggested[72] that s.8(3) saves the effectiveness of the parent's consent in such a case: in other words, that the parent's consent was effective at common law where the minor refused, and in making effective the minor's consent, s.8(3) is not to be construed as making the parent's consent ineffective in these circumstances. Howwever, it is doubtful how far at common law the parent's consent would have overridden the child's consnet; much might have turned on the minor's age, especially since majority was then 21.
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> Secondly, on the interpretation referred to above s.8 would put the

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[71] David Foulkes "Consent to Medical Treatment" (1970) 120 New L.J. 194, 195.

[72] Current Law Statutes: note on s.8(3)

> decision to give consent in the minor's hand, but at the same time enable his withholding of consent to be overridden. Granted that s.8, in terms, merely makes effective what would otherwise be ineffective what would otherwise be ineffective, it is suggested that it is too restrictive a view of its provisions. In its evidence to the Latey Committee, the Medical Protection Society suggested that while the consent of a person of 16 or 17 should be valid, the refusal of such a person should be capable of being overridden by his parent. On the other hand, the B.M.A. said, "of course the refusal of a person over 16 to undergo treatment should also be respected. . ." (Cmnd. 3342, para. 480). The Committee made no observation on this point. The right conclusion, it is suggested, is therefore that where a minor of 16 or 17 refuses consent, that refusal must be given effect to, to the exclusion of all others. Where a person of 16 or 17 gives or withholds consent, it would not seem improper for the doctor to inform the parent of that fact, unless the patient forbids him to do so.

Prior to the Act of 1969 the law was not clear at all.[73] The common law position was that the mature minor could effectively consent to his medical treatment, when he was able to understand the nature, risks and consequences of this treatment. The effect of section 8(3) may also be to continue the effectiveness of that consent, even in cases where the minor is under sixteen years of age, but can be considered as mature.

Another implication of section 8(3) may occur in the situation in which the doctor refrains from seeking the

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[73] See *Supra*, p. 3 etc.

consent of the minor and seeks only that of the parent.[74] The minor's consent has not been given, not because it is refused, but because it is not sought. In this situation it may be that in so far as the parent's consent was effective at common law, its effectiveness is continued by section 8(3).

Finally section 8(3) also covers situations in which there is an emergency and consent cannot be immediately obtained. The common law says that in such cases no consent is necessary, and this rule is saved by section 8(3).

2. Canada

In Canada there are three provinces which deal with the matter of minor's consent to medical treatment in a statute, i.e. Quebec, Ontario, and British Columbia.

In Saskatchewan a private member's bill was debated in April and May 1973. The aim of the bill was to fix at 16 the age of consent to medical (but not dental) services, excluding abortions. The bill proceeded to second reading but was finally defeated.[75]

Of great importance are the proposals of the Conference of Commissioners on uniformity of legislation, which will also be discussed here.

Quebec

The first legislative action in Canada was taken

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[74] See *Supra*, note 71 p. 195.

[75] Bill 101, an Act to amend the Medical Profession Act. See Debates and Proceedings, 17 April 1973, 2032-2850.

in 1972, when Quebec enacted legislation enabling a minor of 14 or over to consent to medical care and treatment required by his state of health.

The provisions are to be found in division 6, articles 36 and 37 of the Public Health Protection Act[76] and read as follows:

DIVISION VI

SPECIAL PROVISIONS RESPECTING

ESTABLISHMENTS AND PHYSICIANS

> 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 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 the person is a minor, the consent of the person having paternal authority shall not be required.

In an article in the Canadian Bar review Paul

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[76] See *Supra*, note 57.

Crepeau comments on the new provisions.[77] He states that the provisions must be looked upon in the context of the articles 18 and 19 of the Civil code of Quebec, which say:

> 18. Every human being possesses juridicial personality.
>
> Whether citizen or alien, he has the full enjoyment of civil rights, except as otherwise experssly provided by law.
>
> 19. The human person is inviolable. No one may cause harm to a person of another without his consent or without being authorized by law to do so.

He further explaines that the new legislation is meant to establish a fair balance between the legitimate interests of the parties concerned i.e. the minors, the parents and, the medical authorities and hospitals.

In discussing the articles Crepeau distinguishes between an intervention in the interest of a child less than 14 years old and an intervention in the interest of a minor over 14 years of age.

In the case of a child less than 14 years old the law provides that, in case of danger for the child's life, a doctor or hospital can provide medical treatment without it being necessary to obtain parental consent.

If however the life of the child is not in danger it is necessary to obtain parental consent up till the moment

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[77] Paul A. Crepeau, "Le Consentement du mineur ten matiere de soins et traitements medicaux ou chirurigicaux selon le droit civil Canadien," Canadian Bar Review Vol. Lll p. 247-261.

that the child becomes fourteen.

In case parental consent is impossible to obtain or refused contrary to the best interest of the child, a Judge of the Superior Court may authorize the care or treatment of the child.

In cases where the child is over 14 years old, the situation is different. According to Crepeau the question to be solved is: Whether a doctor may intervene at the request of the minor alone, without obtaining parental consent or even despite opposition of the parents; and is he allowed to intervene at the request of the parents alone without consent of the minor himself or even despite his refusal? The answer depends on which of the two following postulates is dominating. On the one hand there is the perrogative of the parental authority, which gives the father the authority over his child and makes him responsible for his well being. According to this principle parental consent cannot be dispensed with.

On the other hand there is the principle that a minor, endowed with discernment is legally competent to enter in a binding contract, provided he does not suffer any lesion.

We may assume that a medical contract usually is to the advantage of the minor and in that case only the consent of the minor is essential and the consent of the parents will not be of any influence. Only he has the right to determine for himself what shall be done with his own body.

With article 36 the legislation has meant to give

a minor over fourteen years of age the sole right to consent to medical care and treatment. Before article 36 was adopted, there were two other versions. Crepeau discusses them in his article. The first version provided that only in a number of selected diseases parental consent was not necessary. Those were diseases related to pregnancy, alchohol and drug abuse etc. This provision encountered a lot of criticisms and therefore a second version was drafted which read:

> "An establishment or a physician may provide a minor all the care and treatment his state of health requires without being required to obtain the consent of the parents tutor curator or person having custody of the minor."

The text does not refer to provisions in the Civil Code with regard to the capacity of minors and therefore the comments of Parliament were that the text was not clear at all. Was the provision applicable to all minors or only to minors endowed with discernment like the provision in contract law?

If all minors are meant what about the parental authority. And if only minors endowed with discernment are meant, what are the criteria for discernment?

To avoid all the problems, which the second version created, a third version, the present article 36, was drafted, in which the age of fourteen was established as "the age of majority" in matters regarding consent to medical care and treatment.

The text of article 36 is clear and does not need

any further explanation. Crepeau says that the article seems to be a reasonable solution. The principle of the potential authority and the principle of autonomy of every human being are reconciled.

One aspect of the Quebec legislation troubles me. Article 36 says that an establishment or a physician *may* provide the care and treatment required by the State of health of a minor fourteen years or older with his consent without being required to obtain the consent of the person having parental authority. That means that the care and treatment also can be refused. It is up to the hospital and the doctor to decide whether they think the consent of the minor alone is sufficient. The minor, in seeking care and treatment, is dependent on their discretion in cases where he does not want his parents to be informed about his particular problem. I have therefore my doubts that the Quebec legislation has served the interests of the minors in all respects. Especially in cases where minors need help, for example a fourteen year-old girl, who is asking for an abortion, this help might be refused, although according to article 36 her consent is sufficient.

In the parliamentary committee for Social Affaires this point was discussed also.[78] One committee member proposed to change the word "May" in "Shall". The proposal was rejected because the medical profession has a right in non-emergency cases to accept or to refuse a patient.

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[78]See Journal des Debats -Commission permanente des Affaires Sociale - Les 13 et 14 decembre 1972 No 123, B-7926.

Upon questions from some committee members an explanation was given for the choice of the age of fourteen.[79] The minister of Social Affaires said that there were physiological reasons and also that there was some similarity with "les lois pour le cinema." He admitted that the choice of the age of fourteen was less or more arbitrary, but that it nevertheless reflected social reality. In this society children of 14 years and over have serious problems in cases where they are addicted to drugs or fear to become pregnant or are pregnant and go to the wrong places to look for help as long as they need parental consent for treatment.

Ontario

In contrast with the other jurisdictions which enacted legislation by amending a statute, Ontario brought a change by amendment of a regulation. Regulation 729[80] made under The Public Hospitals Act[81] of Ontario contained a provision, section 49, which prohibited the performance of a surgical operation on a patient unless a consent in wirting for the performance of an operation had been signed by the patient or the parent or guardian of the patient if the patient was unmarried and under 18 years of age. This was the case even before the age of majority was lowered to 18. An exception was made for emergency situations.

The Public Hospital Act authorizes regulations as

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[79] Ibid: B-7925, B-7926, B-7928.

[80] R.R.O. 1970.

[81] R.S.O. 1970 c. 378.

regulation 729 to be made with respect to hospitals as are necessary for certain management purposes. Regulation 729 cannot deal with practise elsewhere than a public hospital.

Regulation 729 was amended in 1974.[82] A couple of changes were made. The first one, relating to surgery, reduced the age from 18 to 16 and the second dealt with diagnostic tests and medical treatment. Section 49 currently reads as follows:

> 49. No surgical operation shall be performed on a patient or an out-patient unless a consent in writing for the performance of the operation has been signed by,
>
> a) the patient or out-patient, as the case may be, where the patient or out-patient is,
>
> i) sixteen years of age or over or
>
> ii) married;
>
> b) a parent, guardian or next-of-kin of the patient or out-patient, as the case may be, where the patient or the out-patient is unmarried and under sixteen years of age; or
>
> c) the spouse or a parent, guardian or next-of-kin of the patient or out-patient, as the case may be, where the patient or out-patient is unable to consent in writing by reason of mental or physical disability.
>
> but where the surgeon believes that delay caused by obtaining the consent would endanger the life or a limb or vital organ

[82] by Reg. 100/74 See O.G. 9 March 1974, 970.

of the patient or out-patient, as the case may be,

d) the consent is not necessary; and

e) the surgeon shall write and sign a statement that a delay would endanger the life or a limb or vital organ, as the case may be, of the patient or out-patient. O. Reg. 100/74, s 11, part.

49a. Where the attending physician or or the administrator is of the opinion that a consent in writing should be obtained before a diagnostic test or a medical treatment procedure is performed on a patient or an out-patient, such consent shall be signed by,

a) the patient or out-patient, as the case may be, where the patient or out-patient is,

i) sixteen years of age or over, or

ii) married;

b) a parent, guardian or next-of-kin of the patient or out-patient, as the case may be, where the patient or out-patient is unmarried and under sixteen years of age; or

c) the spouse or a parent, guardian or next-of-kin of the patient or out-patient, as the case may be, where the patient or out-patient is unable to consent in writing by reason of mental or physical disability. O. Reg. 100/74, s 11, part.

Horace Krever comments extensively on the new provision.[83] He says:

[83] See *Supra*, note 3.

"It is to be observed that, contrary to the impression that was created at the time theamendment was announced to the media, no mention is made of abortion and nothing is said to justify the application of the lowered age to the practice of physicians elsewhere than in the hospital context. The application to out-patients cannot overcome the reality that the regulation is concerned with hospital management. My fear is that this new amendment has given the impression and, perhaps, a false sense of security, to members of the medical profession that a consent of a child over 16 is full authority to the physician, and that a child under 16 may, in no circumstances other than an emergency, be treated without parental consent. My own view is, as I have indicated, that the amendment accomplishes no such result. To the extent that it is intended to change the substantive law, it is, again in my opinion, ineffective since that result could not be brought about except by, or under the express authority (and there is none here) of, a statute that must go through the ordinary legislative process in the House; a regulation, as the exercise of subordinate legislative power in our parliamentary system is, in the absence of express provision in the parent statute, ineffective in changing substantive law. Putting it another way, and again using the technical jargon of lawyers, if the new regulation purports to legislate with relation to the liability and rights of physicians *generally* (and not simply with relation to hospital management) it is, once more in my opinion, *ultra vires*, because it is not so authorized by the parent statute, The Public Hospitals Act. To repeat, the Act empowers the Minister to make regulations in respect of public hospitals, *not*

> physicians and surgeons, so that, at most O. Reg. 100/74 affects hospitals in their practice of requiring consents, since it can only validly regulate hospital management.
>
> What concerns me most about the new regulation is something I have already adverted to and that is the wisdom of fixing any arbitrary age. Now the effect of the amendment may be to deter a physician from treating ayoung person who is a few days younger than 16 years of age. On the other hand, are all 16-year olds mature enough to be able to make all such important decisions independently? Remember, if the consent of a 16-year old is all that is needed for an abortion, which is a surgical operation, so it is for a sterilization operation. If the matter were debated in the House, would the Legislature inevitably agree that a vasectomy or tubal ligation, not *medically* indicated, should readily be available to 16-year olds without parental consultation? Perhaps, but I for one would be less uneasy if there had been more public participation in the decision as would have been the case had the issue been debated in the Legislature. Finally, on this point, even if fixing the arbitrary age of 16 by statute is the correct solution to this difficult social problem, at a time when everyone recognizes the need to develop alternatives to the hospital for ambulatory care, is a solution which applies only to hospitals not a little short-sighted?"

Krever made it clear that the amendment of Regulation 729 certainly is no change in substantive law and

therefore in fact does not change the legal relationship between doctor and patient. Urgent social problems like supplying minors with contraceptives, without parental consent are not solved by this amendment. It is also advisable to deal with legislation with regard to minor's consent to medical treatment in statute form to achieve that the public opinion via the parlamentary process is laid down.

British Columbia

British Columbia enacted legislation in 1973. This enactment is contained in section 23 of the Infants Act[84] which reads as follows:

> 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 constitute 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 practioner, 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.

. . . . . .

[84] See *Supra*, note 54.

(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 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.

The British Columbia provisions are discussed by R. Gosse.[85] The first reading of Bill 37 to amend the Infants Act was with the exception of subsection (4), presently subsection (5) almost identical to the English legislation enacted in 1969.

With regard to subsection (4) of the first reading

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[85]Richard Gosse "Consent to Medical treatment: a minor digression", U.B.C. Law Review, Vol. 9, 1 p. 56-84.

(thus the present subsection (5)) Gosse remarks:

> Subsection (4) appears to be contrary to the spirit of subsection (I). An equivalent provision was not included in the English statute because of the strong view held by the Latey Committee that it should be left to the minor to decide whether his parents should be informed. If the purpose of subsection (I) was to confer a right to medical treatment, without the involvement of parents, it would seem to follow that the minor should be entitled to confidentiality. It should be up to the minor to decide whether his parents be informed. The Latey Committee felt that the doctor should in every case make contact with the parents of the minor, for reasons of ethics and prudence, unless the minor refused permission, such communication being a matter for the doctor and his minor patient. Subsection (4) detracts from the essence of the doctor-patient relationship. If a minor knows that the doctor has the right to inform his parents, he may be reluctant to seek the treatment he needs. In addition, the subsection imposes an unfair burden on doctors. In what circumstances are they to consider it "advisable" to inform the parents? What guidelines are to be used in the case of sixteen-year old girl who wants an abortion, or when an eighteen-year old boy has syphilis or is addicted to heroin?[86]

The second reading was accompanied by a short statement of explanation by the Attorney General, which is criticized by Gosse because of the lack of background information given.

> "No data were given to demonstrate a need

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[86]See *Supra*, note 71, at p. 70.

> for legislation. . .No reference was made to existing medical and dental practise in treating older minors. More important, the Attorney General unfortunately chose to emphasize that the provisions of the bill would assist young people without parents or young persons, who because of the nature of their problem, did not wish to reveal who their parents were. ...he also referred to emergency situations.[87]

The bill was received with a mixture of antagonism and caution. The lack of an obligation to consult the parents or get them involved was heavily criticized. This resulted in an amendment by Liberal member Mr. L.A. Williams. The amendment proposed the addition of the words, "subject to the provisions of subsection (3)." to section (23)1 of the Infant's Act and the substitution of the original subsection (3) (which was the same as subsection (3) of the English Act) by a new subsection (3).

> The purpose of the amendment, Williams said, was to ensure that before a medical practitioner or a dentist carries out treatment,
>
> . . .upon an infant over the age of 16, he should first be obliged to establish that he's made a reasonable effort to obtain the consent of the parent of that child. If he has made a reasonable effort and if the consent is refused, then the second portion of my amendment would permit the medical practitioner or dentist to give the treatment or undertake the procedures if he receives the confirmation from another medical. . . .[88]

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[87] See *Supra*, note 71, at p. 71.

[88] See *Supra*, note 71, p. 75-76.

In the first proposed amendment subsection (3) commenced with the words "if the parent or guardian has refused consent". In a later suggested amendment Williams proposed to delete those words to cover also the situation in which a parent could not be located.

Two points should nevertheless be noted. The words of the present subsection (3) say that the doctors don't have the option of seeking parental consent or obtaining a second opinion from another doctor. They must first try to get parental consent. Secondly, the question is how to define the word "reasonable".

It is clear that because of subsection (3) the desireable aims of legislation on the subject of minor's consent are not reached. Gosse formulated those aims as follows:

1) To clarify the law in order that minors, in the absence of parental consent, will not be refused medical treatment for the reason that the law is misunderstood or is confused;

2) to recognize that all minor children have a right to adequate medical care and, to meet that end, to establish appropriate procedures for dispensing with parental consent where the parents are unavailable or refuse consent in situations where the health of the child, without medical care, would be jeopardized;

3) to encourage older minors with medical problems to seek treatment by ensuring that they can consent to such treatment and by guaranteeing

them a right of privacy.[89]

Therefore in his opinion "the addition of section 23 to the Infants Act of British Columbia cannot be regarded as acceptable. A better result would have been obtained had a proper study of the subject first been carried out and made available to the legislators".

The Uniformity Commissioners' Approach

The sutdy of the Age of Consent to Medical, Surgical and cental Treatment was undertaken in 1972 by the Ontario Commissioners of the Conference of Commissioners on Uniformity of Legislation in Canada. A resolution, submitted to the conference and passed by the council of the Canadian Medical Association in June 1972 was the instigation for this study. The C.M.A. advocated in the resolution the age of sixteen as the age of consent.

At the 1973 meeting of the conference the Ontario Commissioners presented their report. The following sections from the report are of interest:

> The research which we have conducted establishes clearly that the reason for the interest and desire on the part of the medical profession for a change in the law respecting medical treatment of minors cannot be attributed to any spate of cases imposing legal liability on physicians and surgeons for assault. The cases simply do not exist. Neither have we found any substantial problem

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[89]See *Supra*, note 71, p. 67.

with respect to surgery to be performed on minors arising from accident or illness. Procedures for obtaining required consents in this area are well established and known. It is equally clear however, that a problem does exist concerning the non-emergency treatment of minors where the requirement of parental consent is an inhibiting factor. These situations arise chiefly in the area of advice and treatment of cases engendered by the newly found (or taken) freedom of sexuality and the non-medical use of drugs. That the medical health of these young people should be of concern to the profession is a fact not to be deplored. That they should be apprehensive with respect to potential legal liability is understandable. That parents should be made aware and have an opportunity to intervene and assist, however, is also something that is not to be deprecated unless there are serious countervailing factors.

Faced with this dilemma the Conference is called upon to act. There would appear to be three alternative courses of action.

1) The Conference may refrain from taking any action until such time as the legislative policy of the respective governments is settled and the prospect of the adoption of uniform legislation becomes more of a reality. The disadvantages of this solution are obvious engough. Young people will continue to seek medical assistance, and they will receive it, the existing law notwithstanding. More serious cases may give reason to pause but we cannot expect our youth to be attracted to this solution or to us.

2) The Conference may choose to formulate and present remedial legislation directed towards

isolated and designated areas without attempting to cover the broad spectrum of all medical treatment of minors. There is sound precedent for this in adopted legislation dealing with human organ transplantation and under The Venereal Diseases Prevention Acts.

3) The third alternative is to formulate and recommend for adoption a comprehensive statute dealing with the whole question of minors' consent to medical and dental treatment.

   a) that a model act to be known as The Consent of Minors for Health Services Act be drafted;

   b) that the act should define "health services" in terms braod enough to include medical, surgical, and dental advice and treatment;

   c) that the age of consent be fixed at sixteen years;

   d) that there be a further provision dispensing with the need for parental consent for those under the age of sixteen where in the opinion of the attending physician or dentist supported by the written opinion of the attending physician or dentist, supported by the written opinion of one other medical practitioner or dentist,the minor is capable of understanding the nature and consequences of the treatment and that the medical, surgical, psychiatric or dental treatment and the procedure to be undertaken is in the best interest of the continued health and well-being of the minor;

   e) that the act contain a section codifying the common law principle dispensing with parental consent in emergency situations where life is at risk;

f) that the regulation governing consent for surgical treatment under *The Public Hospitals Act* be repealed and that the substance of that regulation be enacted in the new act in an extended form to include situations where health is at risk:

g) that the act provide for more rational and expeditious procedures for dispensing with parental consent in those situations which, at present, are dealt with by resorting to the expedient of making the minor a ward of the court;

h) that the act contain such further qualifications and conditions such as section (23) (3) (a) of *The Infants Act* of British Columbia and the proposed section 69A (3) of *The Medical Profession Act* of Saskatchewan, as the Conference thinks desireable.

The 1973 meeting of the Conference resolved that the Ontario and Quebec Commissioners report and submit a comprehensive draft statute of general application at the next meeting.

The first draft Medical Consent of Minors Act was, following an extensive discussion, referred back to the Ontario Commissioners at the meeting of 1974 to incorporate the decisions and recommendations of the metting.

The second draft read as follows:

MEDICAL CONSENT OF MINORS ACT

(As redrafted and disapproved)

1. In this Act, "medical treatment" includes surgical and dental treatment and any procedure undertaken for the purpose of diagnosis, and includes 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 treatment; and

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

(2) Where a minor who has not attained the age of sixteen years is incapable of understanding the nature and consequences of medical treatment and in the opinion of a legally qualified medical practitioner or dentist attending the minor, the medical treatment is necessary in an emergency to meet imminent risk to his life or health, the consent of the minor or of his parent or guardian is not required.

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 that 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: 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; and certain other procedures to be excluded, concerning the procurement of a miscarriage.[90]

This draft however was disapproved by the Commissioners for Alberta and Commissioners for Manitoba. Therefore the Act was not adopted nor recommended for enactment by the conference. The subject will appear on the agenda of the 1975 annual meeting for further consideration.

The reasons for Alberta's disapproval are the following:

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[90]See 1974 proceedings of the fifty-sixth annual meeting of the Uniform Law Conference of Canada, Appendix L1, p. 120.

1) The Alberta Commissioners are not satisfied that the definition of "medical treatment" in section 1 is adequate.[91]

2) The Alberta Commissioners feel that section 3, subsection (2) is inadequate in that it does not extend to the case of a child under 16, who is conscious and capable of understanding the nature and consequences of the treatment but who cannot physically indicate his consent or refusal of consent because of paralysis or whatever.

3) The Alberta Commissioners feel that the conference should in one way or another cope with the problem in regard to the Alberta Child Welfare Act definition of "neglected child". Section 14 (3)[92] reads:

> (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;

Subclause (x) is predicated on the need for parental consent to medical treatment for minor children. Section 2 of the draft Act obviates the need for that consent in the case of 16 and 17 years old. How would the courts

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[91] See *Supra*, p. 22 and note 58.

[92] R.S.A. 1970 C 45.

read the two together?[93] This would be a volatile issue in any legislature. Perhaps it cannot be dealt with in the draft itself, but it might be in a note to the Uniform Act or in a separate motion at the conference.

3. The United States

Many of the states have dealt with the problems of minor's consent to medical treatment by statute. The following survey sets out the law in 50 states, and the District of Columbia. The survey is derived from the Hospital Law Manual[94] and is up to date till February 1973. Not all the provisions on consent are set out and anyone who wants to get absolute complete information should check the laws of the State concerned. For citations see the above mentioned manual.

It should be noted that:

a) 20 states have statutes which give general provisions for minor's consent to medical treatment. The age of consent varies from 14-18 years old. A number of states use the word "emancipated minor" which means a minor who is living separate and apart and who is managing his own finances.

b) 19 states have provisions which say that the effect of marriage of a minor is that he or she may consent to medical treatment. Sometimes it is provided that annul-

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[93] We will discuss the questions arising out of the Child Welfare Act in Chapter VII.

[94] Aspen Systems Corp., 1973, See also Survey table, Tom Kirk "Capacity of Minors to Consent to Medical Treatment" in Law Reform Reconnaissance Programme, Part II Legal Research Institute of the University of Manitoba, July 1974.

ment or divorce has no effect on adult status once attained.

c) 46 states statutes have prosivions that say that a minor can consent to examination and treatment with regard to veneral disease. Sometimes there is an age quoted varying from 12-16 years old, sometimes the provisions say that any minor can consent.

d) 22 states deal with the problem of minor's consent to treatment for drug abuse. In 16 states any minor may consent to treatment in 5 states the age limit is 12 years and in Texas it is 13 years.

e) In 16 states any minor can consent to medical treatment for pregnancy. In two states the age of consent is 12, in one state it is 15 and in another one it is 18. Sometimes the capacity to consent is limited (for instance when parents cannot be located) or is the capacity to consent to abortion excluded.

f) In 16 states a minor parent can consent to medical treatment for his or her child.

g) Most of the states allow a minor 18 years of age or older to consent to voluntary and non compensatory blood donations (In Delaware the age is 17).

h) Many states have enacted an emergency section to codify the common law.

i) Many states set out that the parents may be informed by the physician of the examination or treatment of their child. The decision to inform is up to the physician. A few states set out that the parents must be informed.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISIONS
Arizona	18 (in general)		Allows minor to consent (subsequent annulment or divorce has no effect on adult status once attained.)	Allows you to consent.	Any minor to treatment of veneral disease.	At 12 if found to be under the influence of drug or narcotic. (This is also considered an emergency & consent of minor is implied.)	Female over 12 may consent where not possible to contact parents in time & girl alleged to be a victim of rape.			At 18 for blood donation - in emergency by person in Loco parentis where there has been an unsuccessful attempt to find parents.
Arkansas	21 (men) 18 (women)				Any minor to treatment of V.D.					At 18 for blood donation.
California * See footnote 93	18		allows consent	Any emancipated minor at 15 (idea of living separate & apart & managing own finances.)	At 12 to infectious, contagious, or communicable (reportable) disease.		Unmarried pregnant minor may consent to treatment of her pregnancy including therapeutic abortion [see Ballard v. Anderson] (1971), 484 P.2d.872 (U.S.D.C. of Dist. of Calif.			

* 93.
See James A. Baker, "Medical Care and the Independent Minor" (1969-70), 10 Santa Clara Lawyer 334, who criticizes the ambiguity of the California consent law. He further says that the statute sets out that the minor should pay for the services; and that implies a contract which the child cannot make unless for necessaries. Clearly not all treatment will be strictly necessary. Further he says at p.344 that the statute does not solve the problem of the minor under psychological separation at home.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISIONS
Colorado	21	-at 18 (if living at home) to medical & Surgical care. -at 15(if living separate & apart & managing own finances).	married minor at 15 to medical, dental & surgical care	See general provisions	Any minor to treatment of V.D.	Any minor to treatment of drug addiction. -no liability except for negligence.			Minor parent may consent for child or ward.	-At 18 for blood donation.
Connecticut	As at common law	At 18 to medical, dental, or health or hospital service.			Any minor to treatment of V.D	Any minor for treatment of a controlled drug.			Married or has been married or borne child - may consent for their child.	-At 18 to transplants and blood
Delaware	18		Allows you to consent for yourself and spouse		At 12 you can give written consent to treatment of communicable disease.		At 12 you can give written consent to treatment of pregnancy or abortion.		Minor parent may consent for child.	-At 17 to blood donation -by minor or person serving as temporary guardian to treatment of any laceration fracture, or other traumatic injury or any treatment which, if delayed, may threaten life or health(Only good after attempt made to contact parents). Will

STATE	1 AGE OF MAJORITY	2 GENERAL PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCI-PATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISIONS
District of Columbia	As at Common Law	Women at 18 to any form of medical treatment								
Florida	21 or upon marriage				Any minor to treatment of V.D. if he/she professes to be afflicted.		If married or a parent, or pregnant, or with consent of parent, or if he may suffer health hazards you may receive maternal health & contraceptive information & services of non-surgical kind. (Non-permanent internal contraceptive devices are included as non-surgical.)			-Any minor to emergency treatment if parental consent not immediately obtainable. -At 18 to blood donation.
Georgia	21	At 18 for yourself	Any married minor for himself or spouse		Any minor to treatment of V.D.	Any minor to drug abuse treatment.	Any female for pregnancy or prevention thereof or childbirth. -Not applicable to abortion and sterilization.		Parent whether minor or adult for his child.	-Any person at 18 may refuse to consent to treatment on his own person. -Where no parent available any person in Loco parentis even temporarily, and any grandparent for minor grandchild, & any adult for minor brother or sister.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT ... OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISIC
Hawaii	18 (minor is anyone 14-17 for their consent law)				Any minor to treatment of V.D. (must tell parents if minor is afflicted. May tell if not afflicted).		Any minor to treatment of her pregnancy.			
Idaho	18 or when married				At 14 to infectious, contagious or communicable diseases.	Any minor for treatment of drug dependency. (No disclosure without minor's consent if minor over 16.)				-at 18 to donation of body or part thereof to research or transplant, & to blood donation
Illinois	18		Allows consent to medical & surgical treatment		At 12 to V.D. treatment	At 12 to drug abuse treatment	Any minor may consent to medical & surgical care.	Married, pregnant or parent, to birth control information and services or who has parental consent or if failure to provide could constitute a serious health hazard or if referred to the health care service.	Minor parent for child.	-At 18 for blood

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVIS
Indiana	21		If married & living with spouse you are competent to contract for medical services.	If emancipated & married, than spouse must join in consent.	Any minor for V.D. treatment.				Minor parent may consent for child.	--At 18 for blood donatio
Iowa	19 or when married.				At 16 to care of V.D.					At 18 for blood donatio
Kansas	21 or 18, if married.	Any minor at 16 when no parent or guardian immediately available.			Any minor to treatment for V.D.	Any minor to treatment for drug abuse.	Unmarried pregnant minor to treatment if no parent available.		Married minor may consent for child.	At 18 for blood donatio
Kentucky	18 (in general)	If emancipated, married, or has borne child, can consent for himself/herself & his/her child (annulment will not deprive you of adult status once obtained.)			Any minor may consent to treatment of V.D.	Any minor may consent to treatment for drug abuse or addiction, or alcohol abuse.	Any minor may consent to treatment of her pregancy.	May advise and treat for contraception not amounting to sterilization.		Medical, dental, or health service can be given if risk to life or health is such that treatment should be given without delay.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISI
Louisiana (See footnote * 94)	18	Consent to treatment may be given by a minor who is or believes himself to be afflicted with a disease.			Any minor may consent to treatment of V.D.	Any minor may consent to treatment for drug abuse.				At 18 for blood donatior
Maine	18				Any minor may may consent to treatment for V.D.	Any minor may consent to treatment for drug abuse.				
Maryland	21	May consent at 18.	May consent if married or parent of child.		Any minor may consent to treatment.	Any minor may consent to treatment.	Any minor may consent to treatment for her pregnancy.	Any minor may consent to contraception not amounting to sterilization.	Minor parent may consent for child.	Minor may consent if delay would endanger life or health. -At 18 for blood donation -At 16 for emotional disorders

*94. An interesting statement of the legislative intent in passing the Louisiana Consent Law is found in La. Stat. Ann. 1965, Paragr. 40:1095 (West,Supp.1973). The intent as there set out was to ensure that the Louisiana minor citizens might be able to readily seek and receive all beneficial medical care, treatment and advice as deemed necessary and advisable. The legislature resolved that the legislation was to be liberally construed to enable "the minor seeking medical care, related services and advice, to receive the highest degree of such medical care, related services and advice as is possible." This was done to actively and positively encourage the betterment of the health and safety of the citizens of the state.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISIC
Massachusetts	As at Common Law					minor may consent at 12 if found to be drug dependent by 2 physicians.				-At 18 for blood donations. -allows emergency treatment if there is a danger to life, limb, or health
Michigan	18				Any minor may consent to treatment.	Any minor may consent to treatment for drug dependency or abuse or narcotic dependency or abuse.				-at 14 may donate kidney to parent, sibling, or to your child if authorized by court order of probate court having jurisdiction over child.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISI
Minnesota	18	if living separate & apart and managing own finances or has been married or borne child, may consent to treatment on yourself or your child.	See general provisions.	See general provisions.	Any minor may consent to treatment.	Any minor may consent to treatment for alcohol or drug abuse.	Any minor may consent to treatment of her pregnancy.			-At 18 for blood donation -No consent necessary in emergency. -Minor who consents assumes financial responsibility
Mississippi	21	unemancipated minor of sufficient intelligence to understand & appreciate to consequences of of the proposed treatment may give effective consent.	marriage allows you to consent for yourself or spouse if joint consent is necessary.		Any minor may be treated for V.D.		Any female may consent to treatment for pregnancy or childbirth		minor parent may consent for child.	-At 18 for blood donation -Any person in loco parentis may consent for child.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSE T	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISI
Missouri	21	married minor or minor parent or legal guardian for himself, spouse or child			Any minor may consent to treatment.	Any minor may consent.	Any minor may consent to treatment not amounting to abortion.		Minor parent may consent for child	At 18 for blood donation.
					no liability except for negligence.					
Montana	anyone under 19		if married or professes to be married may consent		Any minor who is or professes to be afflicted may consent to treatment.		Any minor who is or professes to be pregnant may consent to treatment			minor can consent to psychological or psychiatric counselling where the need is urgent & the consent of parents can't be obtained in time to offset danger to life, health or safety.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT . . OF EMANCIPA-TION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISIC
Nebraska	20 or when married				any minor may consent to treatment (if under 16, or over 16 and not emancipated - required to inform parents).					
Nevada	21 (men) 18 (women)	married & emancipated minor may consent to medical or surgical treatment			Any minor may consent (can require treatment for V.D. if minor refuses and parents haven't consented.	Any minor may consent.				At 18 for blood donation Consent by person in loco parentis is good if emergency & parents can't be found.
New Hampshire	as at Common Law					May consent at 12				Married or 18 may donate blood.
New Jersey	18		allows you to consent.		Any minor who is or professes to be afflicted may consent		Unmarried minor may consent to treatment of her pregnancy		Minor parent may consent for child	At 18 for blood donation.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISI
New Mexico	18	married & emancipated minor may consent			any minor may consent.		any minor may consent.			
New York	21	at 18, or is parent, or married, or has borne child may consent	see general provisions		any minor may consent				see general provisions.	can treat any person in emergency.
North Carolina	18			Allows you to consent for yourself and child	any minor may consent					at 18 for blood donation. May treat without consent where parents can't be found & it's necessary or emergency & delay would worsen condition.
North Dakota	18				at 14 may consent to treatment.					at 18 for blood donation

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISIO
Ohio	21				any minor may consent.	any minor may consent.				at 18 for blood donation Parents not financially responsible where minor consents
Oklahoma	18				any minor may consent					males at 18 for blood donation.
Oregon	21 or when married	at 15 to hospital care, medical, dental or surgical treatment			at 12 may consent to treatment.			may give information and service without regard to age.		at 18 for blood donation.
Pennsylvania	21	if 18, graduated from high school has been married or preganant, may consent to medical, dental, & health services.			any minor may consent to treatment for a reportable disease		any minor may consent to treatment of her pregnancy		minor parent may consent for child	-at 18 for blood donation. -treatment can be given where delay would increase risk to life or health.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSENT TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELLANEOUS PROVISIONS
Rhode Island	18								minor parent may consent for child	-at 18 for blood donation. -at 16 to routine emergency medical or surgical care
South Carolina	as at Common Law	at 16 and no other consent necessary unless an operation is involved.	allows you to consent						married minor may consent for diagnostic, therapeutic, & post mortem procedures on their minor child	-minor spouse may consent for minor spouse. --minor under 16 may consent to health services of any kind without consent of parent if necessary in opinion of attending physician. -at 18 for blood donation.
South Dakota	18				any minor may consent					at 18 for blood donation.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSEN TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 CONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CON ROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISIONS
Tennessee	18				any minor may consent			if married, pregnant or parent, may consent to contraceptive supplies and information or if minor requests or needs the information & has been referred to the service.		
Texas	21	if neither parent is available, consent by grandparent adult brother or sister or adult aunt or uncle or legal guardian or any person who has custody if he has parental authority to do so.			any person may consent	at 13 to tr atment				at 18 for blood donation.
Utah	nen-21 or when married women - 18 or when married.				any minor may consent.					at 18 for blood donation.

STATE	1 AGE OF MAJORITY	2 PROVISIONS OF CONSENT	3 EFFECT OF MARRIAGE	4 EFFECT OF EMANCIPATION	5 CONSE T TO TREATMENT FOR VENERAL DISEASE	6 CONSENT TO TREATMENT FOR DRUG ABUSE	7 :ONSENT TO TREATMENT FOR PREGNANCY	8 GIVING OUT BIRTH CONTROL INFORMATION AND DEVICES	9 MINOR PARENT FOR CHILD	10 MISCELL-ANEOUS PROVISIONS
Vermont	18				at 12 to treatment	at 12 to treatment				at 18 for blood donation.
Virginia	as at Common Law	under 18 where separated from custody of his parents or guardian and is in need of treatment. Authority to consent is vested in judges, commissioner of public welfare, certain state executive officials or persons in loco parentis.			any minor may consent.	any minor may consent.	any minor over 18 and separated from custody of parents to justified termination of pregnancy.	any minor to birth control, pregnancy, & family planning information.		at 18 for blood donation.
Washington	18				at 14 to treatment					
West Virginia	18				any minor to treatment					at 18 for blood donation
Wisconsin	18									
Wyoming	18									

DITIONS*

olorado	Col. 10 Unmarried minors under 18 cannot legally consent to permanent sterilization without parental or guardian permission.
strict of olumbia	Col. 5. A minor can consent to treatment for V.D. at any public health facility. Col. 7. Minors may be provided with pre-natal and post-natal care. Col. 8. Minors may be provided with birth control information services and devices.
ssachusetts	Col. 5. Minors suffering from V.D. and who are unable to pay for private medical care can consent to examination and treatment at publicly maintained facilities.
ssissippi	Col. 4. Any minor may consent.
w York	Col. 10. At 18 for blood donation. Can treat any person in emergency.
rth arolina	Col 9. Minor parent may consent for his child.
egon	Col. 7. Minors may not consent to abortion.
nnsylvania	Col. 2. If 18 or graduated from High School or has been married or pregnant may consent to medical, dental and health services.
ode Island	Col. 2. 16 years of age or married may consent to routine emergency, medical or surgical care. Col. 5. Any minor may consent to examination and treatment.
uth arolina	Col. 5. Any minor may consent.
nnessee	Col. 10. A minor who is 18 years of age or legally married may consent to a sterilization of convenience.

* Made by the writer of this Research Paper.

The survey is not very complete as to minor's rights to birth control information services, and devices. More information is to be found in a survey of American State Legislation in the Albany Law Review.[95] This survey considers "Statutes establishing or approving publicly sponsored family planning programs, which permit (or do not expressly include) service to minors without parental consent."

The survey shows that 25 states deal in a statute with the problems of birth control and family planning. Four states contain in their statutes provisions with regard to birth control information to minors without mentioning the availability of services and devices for minors. The statutes of the other 21 states say expressly or silently that minors may be supplied with birth control information, services and devices and that parental consent in not necessary. Sometimes those provisions are conditional. Common conditions are:

-The minor has to be married

-The minor has to be a parent

-The minor must have been referred by a physician.

-The minor must be on welfare or public assistance.

A certain age is seldom required.

Both surveys show that there is not much unity in American statute law as to Consent of minor's to Medical

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[95]See *Supra* note 59, see also Harriet Pilpel and Nancy F. Wechsler, Birth Control, Teenagers and the Law: A New Look 1971, Family Planning Perspectives, vol. 3, 3 July 1971 for the updating of the survey.

Treatment. Nevertheless the evolution in American Law should be closely watched, because they show a lot of alternatives from which we might choose. Especially the "emancipated minor" idea is worthwile to consider.

Finally we should mention the Model Act published in February 1973 by the COuncil of Child Health of the American Academy of Pediatrics.[96]

In this Model Act the right to consent is given to minors, regardless of their age, who fall within one of five categories. The relevant provision states:

> Section 3. Notwithstanding any other provision of law, the following minors may give consent to health professionals for health services:
>
> 1) Any minor who is or was ever married or has had a child, or graduated from high school, or is emancipated; or
>
> 2) Any minor who has been separated from his parent, parents, or legal guardian for whatever reason and is supporting himself by whatever means; or
>
> 3) Any minor who professes or is found to be pregnant, or afflicted with any reportable communicable disease including venereal disease, or drug and substance abuse including alcohol and nicotine. . .
>
> 4) Any minor who has physical or emotional problems and is capable of making rational decisions, and whose relationship with his parents or legal guardian is in such a state that by informing them the minor will fail to seek initial or future help. . .

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[96](1973) 51 Pediatrics 293, see also *Supra* note 71.

5) Any minor who needs emergency care, including transfusions, without which his health will bejeopardized.

Gosse comments on these provisions in his article:[97]

> At first glance, the approach of the Model Act seems eminently practical in giving the right to consent to minors who have become "emancipated" or those who, because of particular problems (pregnancy, venereal disease, drug abuse, and other physical and emotional problems), should be encouraged to have medical treatment and who might not seek that treatment if parental consent were required. In principle, however, the Model Act may discriminate against minors who do not encounter these particular problems and remain in their parents' homes to continue their education. . . .
>
> . . .Notwithstanding the right conferred on minors by the Model Act to consent to medical treatment, the health professional is given the discretion to inform the parents or legal guardians of the treatment given or needed within subsection (3) of section 3. That discretion may be excercised however, only when the minor consents to the imparting of the information or when, because of the minor's age or condition, the attending health professional "can reasonably presume" such consent. In addition, one of the following circumstances must exist:
>
> a) in the judgement of the health proffessional sever complications are present or anticipated.
>
> b) major surgery or prolonged hospilization is needed;

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[97] See *Supra* note 87 also note 71.

c) failure to inform the parents or legal guardians would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public; or,

d) to inform the parents or legal guardians would benefit the minor's physical and mental health and family harmony.

. . .The Model Act also contains miscellaneous provisions dealing with emergency situations generally and for cases where, although no emergency exists, delay might endanger the health or life of the minor. It is also provided that where a minor is mentally or physically incapable of consenting and has no known relatives or legal guardians, no consent is required if two physicians are in agreement on the health service to be given. A consent by a minor who represents, falsely or otherwise, that he may give an effective consent under the Model Act is to be deemed effective if the health professional relied in good faith on the representation of the minor.

VI

POSSIBLE LIABILITIES OF A PHYSICIAN FOR TREATMENT OF MINORS WITHOUT PROPER CONSENT

In chapter three we stated that the law of torts protects us against unauthorized invasions of our bodies.[98] Any interference with a person's body without his consent is a wrong that can be dealt with by the tort of trespass

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[98]See *Supra*, p. 8.

to a person.

Consequently a physician, who treats a patient without his consent, can be held liable for trespass of the patient in an assault or battery action. Rozovsky states in an article on consent to treatment:

> Regardless of whether these two torts are considered as one combined tort or separately, it is clear that the effect of them is that an action arises when one person intentionally applies force to the person or body of another without the latter's consent or some other lawful reason. Such an action arises no matter how trivial the touching may be, regardless of any harm that may have been caused and regardless of whether or not the person doing the touching was angry or hostile.[99] It is clear therefore that almost everything which a hospital employee or a physician does to a patient could constitute assault and battery, or in common parlance, assault. It is also clear that one of the essential elements in establishing the tort of assault is that there was no justification for the touching or what the patient did not consent to the touching.[100]
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> . . .Despite the fact that lack of consent is a constituent element of the tort of assault and batterh, the matter is sometimes handled by the courts and by plaintiffs' counsel as a negligence problem. However, it should be noted that when lack of

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[99]Salmond, The Law of Torts, 15th Edition London Sweet & Maxwell 1969 at 157.

[100]Lorne Elkin Rozovsky, Consent to Treatment (1973) 11-1 Osgodde Hall Law Journal, 104.

> consent is discussed in negligence terms, it is usually described as negligence in failing to properly inform the patient,[101] negligence in failing to warn the patient of the risks involved in the medical procedure,[102] or negligence in going beyond the patient's instructions.[103] The removal of more body tissue than was necessary has also been discussed in terms of negligence rather than in terms of assault and battery or a touching outside the consent of the patient.[104] Most Canadian cases, however, deal with the matter strictly as one of assault and battery or treaspass to the person.[105]

Consent to treatment cases usually arise as a result of intentional acts of physicians. Intention is a constituent element of the tort of trespass.[106] Negligence is unintentional.[107] The distinction between negligence and assault or battery is important. Rozovsky sets this out in his article:[108]

> The categorization of the tort as assault

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[101] See *Supra*, note 27.

[102] See *Supra*, note 28.

[103] *Boase v. Paul*, [1931] 1 D.L.R. 562 (ONT. S.C.)

[104] *Wilson v. Swanson*,

[105] See *Supra*, note 100 at p. 105.

[106] Jerome J. Atrens, "Intentional Interference with The Person", in Studies in Canadian Tort law A.M. Linden ed, (Toronto: Butterworth's 1968).

[107] S.R. Speller, Law Relating to Hospitals and Kindred Institutions, (4th ed. London: H.R. Lewis 1965) at 98; also *Winn v. Alexander* [1940] 3 D.L.R. 778.

[108] See *Supra*, note 100.

or as negligence is important where the limitation period is different depending upon the categorization. Most provinces frame their special limitation periods in terms of "negligence in the admission, care, treatment or discharge of a patient" for hospitals,[109] whereas Saskatchewan sets specific limitation periods for all actions brought against hospitals.[110] The latter would of course include assault and battery, and therefore any concern about categorization of the tort would not be based on limitations. A similar problem arises with respect to actions against physicians where limitations sections are often based on "negligence or malpractice". These actions would not appear to include a claim for assault and battery. In the case of physicians, these sections are sometimes included under provincial medical acts and sometimes under Limitations of Actions Acts. Where there is not always a discrepancy in the limitation period depending upon the categoization of the tort, this possibility should be kept in mind and appropriate statutes examined.[111]

The second reason for concern as to the categorization of a tort arising from lack of consent is that to prove assault and battery no injuries are required whereas such proof is required

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[109] B.C., Alta., Ont., N.S., B.B., P.E.I., Nfld.

[110] The Hospital Standards Act, R.S.S. 1965, c. 265, s. 14.

[111] See J.S. Williams, Limitations of Actions in Canada (Toronto: Butterworths 1972) at 232.

in any suit based on negligence.[112]

> The third reason for concern over categoization concerns hospitals only and not physicians since malpractice insurance policies of hospitals usually cover "negligence in the administration of any medical, surgical or hospital treatment" which would leave the hospital uninsured for assault if a court were to interpret the policy strictly. Such a distinction does not concern physicians individually since most physicians in Canada are members of the Canadian Medical Protective Association, a mutual defence association and not an insurance company.
>
> A fourth concern over categorization is that if an action is categorized as assault and battery, medical testimony may not be permitted to illustrate acceptable medical practice since the standard with which the procedure was performed becomes irrelevant.[113] The fact that an operation was necessary and that it was performed satisfactorily is no defence to an action based on trespass to the person.[114]

The pro's and con's of a battery v. negligence action are clearly set out in the San Diego Law Review,[115] with referenct to the *Cobbs v. Grant* case on informed consent.[116]

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[112] In *Mulloy v. Hop Sang*, [1935] 1 W.W.R. 714 (Alta. A.D.) the injury to the patient was not as a result of the trespass and damages were awarded per se.

[113] See P.V. Coffey, "Surgery without consent" (1965), 29 Albany L.R. 342.

[114] See *Supra*, note 112.

[115] Daniel F. Bamberg, "Informed Consent after Cobbs: Has the patient been forgotten?" San Diego Law Review (1973), Vol. 10: 916-291.

[116] See *Supra*, note 33.

> When a doctor breaches the duty imposed upon him by the informed consent doctrine, a patient may have a cause of action based on a theory of battery, or on one of negligence. The particular circumstances surrounding the physician's breach as well as the jurisdiction in which the plaintiff brings his case will determine whether or not it can be based on battery or negligence. This distinction may well be crucial to the plaintiff as it is generally easier to plead and prove a case based on a theory of battery.
>
> The battery theory is more advantageous for the plaintiff because expert medical testimony is not always necessary and proving causation is relatively easy. Additionally, punitive damages are possible, and, should be noted that the physician's insurance may not cover intentional torts. Under a negligence theory, however, the plaintiff has two heavy burdens to carry: producing expert medical testimony and proving causation. To the extent these burdens make the plaintiff's case more difficult to prove, it will of course be easier for the physician to defend a negligence suit.

The article deals with the question of what happens when a physician has failed to disclose the collateral risks inherent in the procedure. Will the liability be based on battery or negligence? The author states that courts who have held the physician liable for battery base this on the reasoning that either the failure to inform vitiates the consent or that uninformed consent is no consent.

The prevailing view however seems to be that liability will be based on negligence. The court supported

this view in *Cobbs v. Grant*:[117]

> [10] We agree with the majority trend. The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.

In the Cobbs case the court was clearly more concerned with the nature of the physician's duty to inform than with the right of the patient to determine what will be done with his own body. The negligence theory is certainly more favourable to the doctor, because it is hard for the plaintiff to produce expert medical testimony and to prove causation.

With regard to the purpose of this research it is necessary to pay special attention to the problem of liability of physicians in contraceptive treatments of minor patients, who are incapable of giving valid consent.

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[117] *Ibid* at p. 8.

In a research paper about "Legal problems involved in the prescription of contraceptives to unmarried minors in Alberta", just recently published in the XII Alberta Law Review, 3, 359 (1974), Richard Gilborn deals specifically with this problem. He says:

> The two main treatments of concern here are the prescription of birth control pills and the insertion of intrauterine devices. With respect to the fitting of intrauterine devices, it would seem fairly certain that this involves a surgical procedure and as such would amount to a battery if no valid consent was obtained.
>
> What of the position with respect to the prescription of the pill? There is definitely no surgical procedure involved, but is there an "application of force" within the technical definition of "battery"? Salmond states:
>
> > Intentionally to bring any material object into contact with another's person is a sufficient application of force to constitute a battery.[118]
>
> Lord Nathan suggests that the mere administration of a drug may technically constitute a battery:[119] "It is a technical assault, therefore, secretly to administer a drug to a patient against his wishes." Of course, in the normal situation, the minor receiving a birth control pill would indeed wish to receive them.

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[118] See *Supra*, note 99 at 157.

[119] See *Supra*, note 6.

If, however, it was held that she was incapable of giving consent would the situation be the same?

A recent article in the United States makes a similar suggestion:[120]

> Since a battery requires only that the doctor intentionally and without consent set in motion a force which ultimately produces a contact, it is possible that any unauthorized medical treatment will also be held to constitute a battery. The physician might therefore commit a battery merely by prescribing a drug for a minor without the consent of the minor's parent.

In order to better determine the validity of these suggestions one should perhaps examine in more detail the cases cited as authority for these propositions. Lord Nathan cites a note found in the medico-legal column of the British Medical Journal[121] concerning an unreported case where a physician was found liable for secretly administering a sedative to an overwrought patient who had refused such medication. The learned judge had found that the physician was liable in contract. However, the author goes on to suggest:[122]

> Presumably to administer a drug without a person's knowledge is a common assualt, but if no ill effects were caused the damages

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[120] Kavanaugh, "Minors and Contraceptives: The Physician's Right to Assist Unmarried Minors in California", [1972] 23 Hastings L.J. 1486 at 1498-1499.

[121] [1949] 1 Brit. Med. J. p. 1100.

[122] Ibid.

> could not be more than nominal unless the court desired to make them exemplary. The assault might also constitute a trivial criminal offence. It would not come under the special provisions of the Offences against the Person Act against the administration of a noxious thing.

Since the case was decided in contrast, it can hardly be said to be good authority for the above statement. In fact no case has been found in Canadian or English jurisprudence which suggests a doctor would be liable in battery for the unconsented administration or prescription of a pill or durg. Presumably no such action would be undertaken if a particular drug is satisfactory. If on the other hand it were to cause ill effecte, the action would probably be based on negligence.[123]

Kavanaugh (n. 120) cites tow cases as authority for his position. Firstly, in *Commenwealth v. Stratton*[124] the defendant was held guilty of criminal assault and battery for secretly administering some "love powder" (cantharides or more commonly called "spanish fly") in a quantity of figs and presenting them to a young lady whereupon she became violently ill. In the second case, *State v. Monroe*,[125] a druggist was found guilty of criminal assault and battery for adding some corton oil (a rather drastic cathartic and pustuland) to a piece of candy in

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[123] e.g., see *Pollard v. Chipperfield* (1952) 7 W.W.R. (N.S.) 596 (Sask. C.A.).

[124] (1873) 114 Mass. 303, [1873] A.L.R. 350 per Wells J.

[125] (1897) 28 S.E. 547 per Faircloth C.J.

in concert with others as a practical joke. Kavanaugh submitted that the definitions of criminal and tortious battery are similar enough that these criminal cases could equally apply to the tortious situation.[126]

Whatever the position may be in the United States, it was and is far from clear in English law. In the early English case of *R. v. Button*[127] the defendant was found guilty of common assault for administering cantharides to some coffee. This case was expressly disapproved in *R. v. Dilworth and Smith*[128] and again in *R. v. Walkden*[129] and *R. v. Hanson*.[130] The confusion for our purposes, is shown in the report of the *Hanson* case. It was argued for the prisoner that:[131]

> . . .[T]he offence charged in the indictment was neither a misdeamnour at common law nor an assault. *It was nothing more than a private wrong, the remedy for which was by a civil action, and not by a criminal proceeding.* [Emphasis added.]

Unfortunately we will never know what the result of a civil action would have been since none apparently was brought. The judgment of Williams J. also gives no clue:[132]

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[126] See *Supra*, note 120 at 149 & note 77.

[127] (1838) 173 E.R. 661 per Serjeant Arabin.

[128] (1843) 2 Mood & Rob. 531.

[129] (1845) 1 Cox's C.C. 282.

[130] (1849) 4 Cox's C.C. 138.

[131] Ibid.

[132] Ibid. at 139.

> Williams, J. (after consultation with Cresswell, J.), said that he was of opinion that the indictment could not be sustained, as the offence charged was not either an assault or a common law misdemeanour. His lordship added, that they were also of opinion that the case was not within 7 Will. 4& 1 Vict. c. 84, which made it felony to deliver to anyone any dangerous or noxious thing with intent to do grievious bodily harm.
>
> The criminal law position was cleared up in 1860 with the passage of 23 Vict. c. 8, which made it a crime to administer a poisen even where the intent was not to commit murder but only inflict bodily harm. The modern versions of this old English statute are found in sections 229 and 230 of the Criminal Code. Unfortunately these do nothing to clear up the position in tort law.
>
> In summary then, it would appear that the question of whether the simple giving of a pill can amount to the tort of battery is far from settled. It is clear under the Criminal Code that if the pill were a noxious or stupifying drug given with the requisite mal-intent a criminal offense is committed. Whether or not the giving of a pill could amount to such an "application of force" as to constitute the tort of battery is at best doubtful --at least until there is some case authority on the point.

We have to agree with Gilborn's conclusion. The situation with regard to prescribing drugs is far from clear. An intensive search for cases and literature did not

produce any evidence that a physician can be held liable by merely prescribing drugs to a minor without parental consent.

It is more conceivable that the insertion of an intra-uterine device can amount to assault or battery, because to insert the device needs an intentional touching.

Apart from a possible liability of a physician in tort laws, we should also investigate the possibility of liability under the Criminal Code, the Food and Drug Act and the Juvenile Delinquency Act.

Under the former Criminal Code, S.C. 1953-54, C. 51 it was an offence to sell or advertise contraceptives. The relevant section was 150(2)(c) and read as follows:

> 150(2) Everyone commits an offense who knowingly, and without lawful justification or excuse. . .
>
> (c) offers to sell, advertises, publishes an advertisement of, or has for sale or disposal any means, instructions, medicine, drug or article intended or represented as a method of preventing conception or causing abortion or miscarriage.

In 1969 Parliament passed an Act[133] to amend the Food and Drugs Act, the Narcotic Control Act and section 150(2)(c) of the Criminal Code. The amendment provided that

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[133] S.C. 1968-69 C. 41.

the words "preventing conception or" were dropped.[134] Selling or advertising of contraceptives was no longer a criminal offense. The Amendment made it clear that it was not absolutely against public policy to prevent contraception. This is important for if it were against public policy any consent to a treatment to prevent conception would be invalid.

The advertising of contraceptives is now regulated by the Food and Drugs Act.[135]

Pursuant to section 2[136] regulations have been made which say as follows:

> c.01.625 Contraceptives drugs that are manufactured, sold or represented for use in the prevention of conception and that are not listed in schedule F. may be advertised to the general public.
>
> [Schedule F. contains only the drug "thalidomide"]
>
> K.01.001 Contraceptive devices, other than intra-uterine contraceptive devices, that are manufactured, sold or represented for use in the prevention of conception may be adver-

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[134] Ibid. s. 13.

[135] R.S.C. 1970 c. F-27

[136] S.C. 1968-69 c. 41 s.2.

> tised to the general public where the means of advertising is other than the distribution of samples of such devices door to door or through the mail.[137]

Thus under the Food and Drugs Act all forms of contraceptives may be advertised to the general public except intra-uterine devices.

The relevance of the Amendment of the Criminal Code and the Regulations under the Food and Drugs Act are that they indicate that it is not against public policy in Canada to advertise, sell or presumably, counsel the use of contraceptive pills or devices. It could therefore be argued that it is hard to believe that a physician will be held liable on criminal grounds for the sole reason that he prescribes contraceptives to anyone in general or to minors specifically. It is also unlikely that public policy with respect to birth control itself is a reason to vitiate the consent of minors to contraceptive treatment.

Next to be mentioned is the possible liability of doctors, prescribing contraceptives to minors, under the Juvenile Delinquents Act.[138] The relevant sections of the Act are:

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[137]See Food and Drug Regulations, (1970) 104 Canada Gazette (Part II) 80, January 14, 1970.

[138]R.S.C. 1970, C. J-3.

2(1) In this Act. . .

"juvenile delinquent" means any child, who violates any provision of the Criminal Code or of any federal or provincial statute, or of any by-law or ordinance of any municipality, or who is guilty of sexual immorality or any similar form of vice, or who is liable by reason of any other act to be committed to an industrial school or juvenile reformatory under any federal or provincial statute;

33(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,

is liable on summary 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. . .

(4) It is not a valid defence to a prosecution under this section either that the child is of too tender years to understand or appreciate the nature or effect of the conduct of the accused, or that notwithstanding the conduct of the accused the child did not in fact become a juvenile delinquent.

A major concern for physicians in that they, in providing minors with birth control devices might be found

guilty of contributing to a child becoming a delinquent. Although the possibility of such a conviction is often mentioned, there is very little probability.[139] In fact no recorded case has been found in North America or England in which a physician has been convicted or for that matter, charged with such an offence.

The problem with the above quoted sections is first of all the very broad definition of "juvenile delinquent", which includes any "child" who is guilty of sexual immorality. The positionin Alberta is that a "child" within The Juvenile Delinquents Act is defined as any boy apparently or actually under the age of sixteen years and any girl apparently or actually under the age of eighteen years.[140] Secondly it is not clear what is meant by the term "sexual immorality". The term is undefined in the Act and not satisfactorily explained in case law. Gilborn refers in his research paper to a report of the Department of Justice Committee on Juvenile Delinquency.[141] The report says:

> 364. There is till another source of potential prejudice to an accused charged with contributing to delinquency. This arises from the inherent difficulty of the concept of contributing to delinquency as an offence category. For what, in fact, does contributing to delinquency mean? And what limits should be observed in receiving evidence in support

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[139] See *Supra*, note 95 and note 120.

[140] See 1951 Canada Gazette (Part II) at 106q.

[141] Macleod, etc., Juvenile Delinquency in Canada (1965) 209.

> of a change?. . .While it is beyond the scope of this Report to trace the development of Canadian case law on the contributing provisions, we should say frankly that in our judgment the courts have yet to articulate a clear test for distinguishing between permissible and prohibited conduct. In many cases, therefore, liability to a criminal sanction will depend almost entirely upon the subjective, and sometimes highly speculative, assessment of the judge as to whether particular conduct is or is not such as to the delinquency of a child. It is true that the statute provides that it is not a defense to a change of contributing "that the child is of to tender years to understand or appreciate the nature or effect of the conduct of the accused, or that. . .the child did not in fact become a juvenile delinquent." In interpreting this provision the courts have said that it was "the evident intention of Parliament. . .to relieve the Court of the necessity of speculating as to whether or not the child's morals were in fact undermines. . ."[*R. v. Hamlin* (1939) 1 W.W.R. 702]. Nevertheless, the judge is often forced by reason of the indefinite character of the concept of contributing to delinquency to make precisely this kind of assessment [*R. v. Cortner* (1961) 35 W.W.R. 187; *R. v. MacDonald* (1936) 3 D.L.R. 446].

In the recent case *R. v. DeWinter*[142] *DeWinter* was

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[142] *R. v. DeWinter*. (1974) 2 W.L.R. 759 B.C. C.A.

convicted of contributing to juvenile delinquency. He had indecently exposed himself to a female child of five. In his judgment Carrothers J.A. said:

> Could it be said that what occured here might possibly engender an unhealthy curiosity or abhorrence in the child tending to corrupt the morals of the child or induce some form of sexual immorality? There is no evidence as to what effect it did or might have upon this particular child, but there is no doubt that the incident did have an immediately disturbing effect on her, whether or not she appreciated or understood what was happening in order to be affected by it. I would suggest this conclusion could easily have been reached had the child bee, say 14 years old, and certainly a five-year-old child, an age considered enough for school, is impressionable and capable of comprehending and being apprehensive of what was occurring so as to be affected by it, even though not fully appreciative of the full impact of the event.

Although this case dealt with the problem of contributing to the sexual immorality of a child the circumstances are so special that the case does not reveal any clue towards the criminal liability of physicians in prescribing the pill to minors.

In the normal case a physician would not be interested in prescribing contraceptives to a minor in order to encourage sexual promiscuity, but would rather act in the interests of the minor's good health. As one recent article

put it:[143]

> On the possibility that such a prosecution might be instituted, we think the physician would be well advised to defend on the ground that the minor had been sexually active, and that in his best professional judgment, he felt that failure to prescribe contraceptives would subject the minor, or the out-of-wedlock children whom she would be likely to bear, to serious health hazards. An argument could certainly be made that the physician's actions (like most medical treatment) were independent of the "delinquent" conduct of the patient, and were intended and needed to avoid adverse health effects of such conduct.

It would also be difficult to show a causal connection between the prescription of contraceptives and the sexual immorality of the patient.[144]

Two more cases are worthwile to mention because they reveal a recent outlook with respect to what constitutes "sexual immorality." Gilborn also refers to

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[143] See *Supra*, note 95.

[144] See for e.g., recent medical studies in the United States, which suggest that the sexual habits of sexually active minors change very little whether or not contraceptives are available,

Gordis etc. "Adolescent Pregnancy: A Hospital Based Test Program for Primary Prevention" (1968) 58 Am.J. Public Health 849 at 857.

Goldsmith etc. "Teenagers, Sex and Contraception" (1972) 4 Family Planning Perspectives, 32; Kanther and Zelnik, "Sexaul, Contraception and Pregnancy Experience of Young, Unmarried Women in the U.S.", (1973) a reprint of two articles in October 1972 and January 1973 issues of Fam. Planning Perspectives available from "Planned Parenthood World Population" 810-7 Avenue New York, N.Y.

those cases in his research. In the first one *X. v. LaReine*[145] the accused, aged 19, won an appeal from a conviction of contributing to juvenile delinquency by having sexual relations with his sixteen year old girlfriend. The court held that extra-marital sexual relations with a minor are not necessarily criminal nor immoral.

The second case comes from the United States. The *State v. McLaughlin.*[146] In that case the defendant was charged and convicted of contributing to the delinquency of her 16 year old daughter, who had already given birth to three illegitimate children. The conduct which allegedly gave rise to this delinquency was the mother's warning to her daughter to use birth control devices if she persisted in her sexual activity and instructions to her daughter as to their use. Such counselling, it was alleged encouraged the child to engage in immoral sexual activities causing her to become a delinquent. The conviction, gained at trail, was overthrown by the Ohio Supreme Court largely on the ground that the conviction violated the mother's freedom of speech. The headnote of the case says:

> A mother's instructions to her pregnant daughter that birth preventative measures should be used in premarital sexual acts did not create a "clear and present danger" of an evil which the state could prevent by abridgment of constitutionally guaranteed right of free speech; neither was there a "clear and present danger" of accomplishing the prohibited crime, i.e., contributing

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[145] (1969) R. I. 122 (Cour Superieure En Appel)

[146] (1965) 212 N.E. 2d. 635 (Ohio C.A.)

to the delinquency of a minor.

Although these legal reasons may not be applicable in Alberta and a mother is in a different position towards her child than the physician is, it might nevertheless be relevant that if a mother cannot be legally "blamed", it is very doubtful that the physician is prescribing contraceptives for such a girl can be held liable.

It might be risky for physicians to prescribe contraceptives to minors under the age of 14 since the criminal code in section 140 provides that an unmarried minor female under that age can never consent to sexual intercourse. In principle the permission of parents with respect to the prescribing of contraceptives to girls under 14 should make no difference to possible criminal liability. In practise, however, if such permission were obtained, it would seem unlikely a charge would arise.

Finally we have to mention the possible disciplinary proceedings, which a physician might face, if he provides minors with contraceptives. In this context the Re "D" case[147] is relevant. The case was an appeal from a decision of the council of the College of Physicians and Surgeons of British Columbia upholding the decision of a medical inquiry committee which found that three of eight charges made against Dr. "D" following the complaints of a 15 year old female

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[147] Re "D" and Council of the College of Physicians and Surgeons of British Columbia, (1970) 11 D.I.R. (3d) 570 (B.C.S.C.).

patient were proven. The charges appealed from were:

> 2. That you have been guilty of infamous or unprofessional conduct in inserting a birth control device in a 15-year-old female patient. . .on or about March 28, 1968 without parental consent.
>
> 3. That you have been guilty of infamous or unprofessional conduct in the intentionally not disclosing the treatment or purported treatment referred to in Charge 2 and further treatment or purported treatment to the same patient on April 13, 1968 to the parents of the said patient at the time of such treatment.
>
> 4. That you have been guilty of infamous or unprofessional conduct in conducting yourself indenctly with a female patient. . .on or about March 28 and April 13, 1968 by kissing her and fondling her private parts.

The appeal against these charges was dismissed Gilborn analyses the case in his research paper as follows:

> MacFarlane J. found on the main question of appeal that the medical inquiry committee made a deliberate effort to find corroborative evidence. For the purposesof this paper, however, the appellant's second main ground of appeal was the most important. It was argued that "there is nothing improper about a doctor taking a 15 year old girl as a patient and giving her medical treatment without the consent of her parents." It was further contended ". . .that once the doctor accepts the patient then he is bound by his code of ethics. . .to keep secret from

everyone, including the parents of the child, what transpires between him, as a doctor, and the child, as a patient."

To this argument the court seems to answer that in some circumstances this may be true, but whether or not a given conduct is unprofessional or infamous in a particular set of circumstances is something best decided by a medical inquiry committee and they had decided that in this case the conduct was unprofessional.

From the standpoint of attempting to derive a *ratio decidendi* this finding by the court is very unsatisfactory. It does not tell us what conduct is unprofessional--i.e., is the insertion of an I.U.D. in a 15-year-old girl without parental consent unprofessional conduct *per se* or does it become unprofessional conduct only on the facts of this case--where there was an allegation of sexual impropriety (which was accepted) and where the parents were informed by the daughter of the insertion of the I.U.D. and asked that Dr. "D" remove it? This question can only be fully answered by subsequent cases. It is submitted, however, that this case should not be cited as authority for the proposition that 15-year-old girls can never validly consent to contraceptive treatment without parental consent. The problem in the case was approached largely as one of fact, there was no question of battery involved, and the court did not even discuss the legal capability of a 15 year old to consent to medical treatment. Perhaps the most one could say this case decides about the problem of a minor's consent to contraceptive treatment, is

> that it is a question of fact in all the circumstances of the case and that it offers little in the way of guidelines for a court or medical inquiry committee to follow in determining such a question.

The solution of these kind of disciplinary proceedings would be that the Medical Associations lay down specific guidelines with respect to unprofessional conduct and the treatment of minors. The Canadian Medical Association passed already a resolution recommending the age of 16 as the age of consent to medical treatment.[148]

In this context it is relevant to pay attention to the position the Medical Defense Union in England has taken. In a memorandum of July 1974 to its members we find the following statement:

> 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 sixteen 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 girls sexual conduct would be removed by the doctor's guidance. The Unions legal advisors 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 sixteen he is not acting unlawfully provided he

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[148] See *Supra*, p. 44.

Should refusal of the parents have effect? The opinions are divided.

David Foulkes says in his comment on the English provisions that where a minor is 16 or 17 years old, and he consents to or refuses medical treatment, the consent or refusal must be given effect to, to the exclusion of all others.[149]

Skegg[150] disagrees with Foulkes and says "a legally effective consent by the parents can sometimes be given even when the minor is capable of consenting, but refuses to do so."[151] According to him section 8(3) of the EnglishAct does not effect this capacity of the parents. He states however that it would be unwise to rely on a parental consent in such a case unless the minor is still subject to parental authority and the proposed procedure is clearly for the minor's benefit.

Another commentator has suggested that once a child has reached the age of discretion, although he is still in the "possession" of his parents, the child has a right to object to a proposed medical procedure, unless his welfare depends upon it.[152]

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[149] See *Supra*, note 71 and p. 29.

[150] See *Supra*, note 5.

[151] For authority of his opinion Skegg refers to two cases: B. (B.R.) v. B. (J.) [1968] p. 466, 473-474 (C.A.); and S. v. McC., v. W. [1972] A.C. 24, 45 (H.L.).

[152] J.M. Eekelaar, What are Parental Rights? (1973) 89 L.Q.R. 210 at 225.

> acts in good faith in protecting the girl against the potentially harmful effects of intercourse.

It should be noted however, that whatever may be the ethical position of particular medical associations, it has nothing to do with the legal position with respect to possible civil or criminal liability and it is only relevant to possible liability to disciplinary actions within the profession itself.

VII

CONFLICT BETWEEN PARENT AND CHILD

Difficulties will arise where parent and child are in conflict on the issue of medical treatment. For instance, a pregnant teenager wants an abortion but her parents are opposed, or that the parents wish the girl to have the abortion, but she is opposed.

Must effect be given to the consent or the refusal of the teenager for the abortion, notwithstanding the opinion pro or contra the abortion of the parents?

It must be noted that this kind of conflict of course also can happen in less serious situations. To solve the inherent questions we have to look into the facts of the conflict situations.

Child Capable of Consenting to Medical Treatment

Suppose the child was, according to common law or statute law, capable of consenting to medical treatment.

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David Foulkes says in his comment on the English provisions that where a minor is 16 or 17 years old, and he consents to or refuses medical treatment, the consent or refusal must be given effect to, to the exclusion of all others.[149]

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[149] See *Supra*, note 71 and p. 29.

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[152] J.M. Eekelaar, What are Parental Rights? (1973) 89 L.Q.R. 210 at 225.

Lord Denning described the legal right of a parent to custody in *Hewer v. Bryant*[153] as "a dwindling right which the courts will hesitates to enforce against the wishes of the child, the older he is. It starts with a right of control and ends with little more than advice."

I personally agree with Gosse[154] that the older minors, who are capable of giving consent to medical treatment, should be entitled to privacy and self determination, particularly in sexual matters. In seeking medical treatment or help a teenager should not be hampered by the possibility of his parents refusal to consent to the treatment sought.

It might nevertheless be wise to lay this down in an Act, if Alberta is going to get one.

In the United States the evolution towards the right of self determination of children is shown in two recent cases.

In the first one *"In re Smith"*[155] it was decided that:

> Mother having custody of her unmarried 16-year-old pregnant daughter could not, for reasons not within ambit of the abortion statute, compel daughter

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[153] [1969] 3 All E.R. 578, at 582 (C.A.).

[154] See *Supra*, n. 85, p. 63.

[155] (1972) 295 A 2d 238 (Maryland C.A.).

> over daughter's opposition, to submit herself to procedures which might lead to an abortion; thus, juvenile court, on finding child in need of supervision, had no power to compel daughter to resort to medical procedures relative to termination of pregnancy on ground that mother wanted her retained by sheriff for delivery to hospital for an abortion at request of mother.

In the second case *"State v. Koome"*[156] the Supreme Court of Washington, with four justices dissenting has overturned the conviction of a physician of performing an abortion on an unmarried 16-year-old minor without first obtaining the consent of her parents, holding that the requirement of parental consent is unconstitutional as an unwarranted intrusion on the minor's right to privacy. The court rejected arguments that the consent requirement was justified by the State's interest in supporting parental authority, strengthening the family unit and insuring informed and considered decision-making by minors. The court held that:

> Even though the family structure is a fundamental institution of our society, and parental prerogatives are entitled to considerable legal deference, they are not absolute and must yield to fundamental rights of the child or important interests of the state.

In this case the parents of the girl and her temporary guardian who had refused to consent to the operation, opposed a petition of the girl to the court for an order, allowing her to have an abortion.

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[156] (1975) Wash. 530 P 2d 260.

The circumstances of both cases showed that both girls could be considered as "mature" minors, although the age of consent in the state of Maryland as well as in the state of Washington is 18 years.

Next, we have to consider the situation, in which the child is under the age of discretion and not legally capable of giving consent to his treatment.

Child Not Capable of Consenting to Medical Treatment

The question we have to pose ourselves here is whether a physician may start or proceed with a medical treatment of a child, although the parents are opposed the treatment and refuse to give consent. Here again the facts of the situation are important and we have to distinguish between the situation in which there is an immediate threat to the life and health of the child and the situation where there is no such threat.

Situation where there is an immediate threat to the life and health of the child:

In situations where there is such threat physicians have a general privilege to act without consent, where there is a failure to procure consent. Nearly all the legislation dealing with minor's consent to medical treatment contains emergency provisions.[157] But it is conceivable that an emergency treatment contrary to the express refusal of consent of the parent can result in liability of the physician,

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[157]See *Supra*, chapter 5.

performing the procedure. The physician might decide to proceed the treatment but he will have to consider first all the facts of the situation, like the complexity and risks of the proposed treatment, the danger to the child if no treatment is undertaken, and the time element. In cases where according to medical judgment the treatment is necessary for the health and well being of the child and the risk and danger to the child are small in comparison to the benefit and where time permits, the physician's treatment should be based upon a proceeding pursuant the child welfare laws.

The Canadian law has long recognized that denial of necessary medical care to a child by parents constitutes neglect for which there are both civil remedies and criminal sanctions.[158] In addition statutes establishing judicial procedures to authorize the treatment of a child without parental consent exist. Under these laws the parents right to custody and control of their child may be terminated, and custody and control transferred, by court order, to an appropriate agency when the child has been determined to be a "neglected child".

We referred to the problems of the Alberta Child Welfare Act (in connection with minor's consent to medical treatment), as mentioned by the Alberta Commissioners for the Uniformity Conference, in Chapter V.[159]

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[158]The amendment of the law for the Relief of the Poor, 31-32 Vict. c. 122 §37, see also *King v. Brooks*, (1902) 5 Can. C.C. 372; *v. Lewis*, (1903) 7 Can. C.C. 261; and C.S. C51 §186 (1953-1954).

[159]See p. 50.

The Alberta definition of "neglected child" is broad in scope, referring to health and well-being which necessitates medical or surgical care.[160]

It is also interesting that the Alberta Statute states that no liability may attach to a physician or hospital for providing necessary medical, surgical or psychiatric care to a child who has been taken into custody because there are grounds to believe the child is neglected (section 17(2)).

Although the Alberta statute is very broad it is questionable whether the courts would invoke a substitute parental authority in cases where failure to provide medical treatment would not constitute a threat to the life of the minor involved. It all depends on what is meant by health and well being of a child.

No Canadian cases have been found on this subject, but there are a number of interesting cases from the United States, which sometimes allow the substitution of parental decisions by court decisions even at times, when surgical procedures are procedures are proposed to remedy conditions posing no physical threat to life.

The first case, *In re Sampson*[161] concerns a boy suffering from a massive overgrowth of facial tissue causing a severe deformity on the right side of his face and neck. Testimony that he had not attended school for ten years and

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[160] See *Supra*, note 92.

[161] 317 N.Y.S. 2d 641, 1970, aff'd, 29 N.Y. 2d 900, 328 N.Y.S. 2d 686 (1972).

had a severe learning disability because of the deformity was presented to show the necessity of treatment. The conclusion was that this disfigurement so limited the child's total development that the court had to assume a responsibility and ordered the surgery, althouth it was acknowledged that the procedure was accompanied by risks. The case was decided by a New York Family Court judge and the boy concerned was 15 years ol.

The Pennsylvania Supreme Court has ruled against the position taken in the *In re Sampson* case in the case of *In re Green*.[162] A physician petitioned the Juvenile division of the county court for his appointment as guardian of the sixteen year old boy in order to authorize necessary medical treatment. The boy suffered curvature of the spine which, according to medical testimony, could be corrected by spinal fusion. The boys mother refused to consent to the surgery because the required blood transfusions were objectional to her religious belief as a Jehovah's Witness. Though the trial court found the child to be neglected under the Pennsylvania statute, it refused to authorize the fusion since it was not necessary to save the child's life, but only to improve his condition, and therefore the states interest was not sufficient to interfere with the mother's religious freedom. The physician appealed and the Pennsylvania Superior Court reversed this decision of the county court and remanded the matter for the appointment of a guardian, restating with approval the Sampson holding, and concluded that it is within the power of the court to act contrary to the parents belief in order to assure the child an opportun-

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[162] 292 A 2d 387 (1972).

ity for a normal life. However, on further appeal by the mother, the Pennsylvania Supreme Court, three Justices dissenting, held "as between a parent and the state, the state does not have an interest of sufficient magnitude outweighing a parent's religious beliefs when the child's life is not immediately imperiled by his physical condition". The Court went on to say that the ultimate question presented by this case is whether a parents religious beliefs should dominate this situation, rather than the possibly contrary decision of the child. The case was therefore remanded for an evidentiary hearing in order to determine the boys wishes.

The dissent expressed the opinion that the question is not one of the balance between the interest of the state in protecting the child and the interest of the mother in her religious beliefs. The primary concern, according to the dissent, should be the health and well being of the child. "Parents may be free to become martyrs themselves" but not to make martyrs of their minor children. The dissent further pointed out that the neglected child statute speaks only in terms of "health", not of life or death. Lastly, the dissent asserted tha the boy, virtually a life-long cripple, under the direct control and guidance of his parents, could not reasonably be expected to make an independent decision when confronted "with a most painful choice between the wishes of his parents and the chance for a normal healthy life".

In the *In re Sampson* case the circumstances of the case indicated that the 15 year old boy would not have been capable to consent to the operation himself. Some earlier

cases show that the courts are more inclined to order medical treatment in non emergency cases despite refusal of the parents in cases in which the minor is of tender years.[163]

In re Green[164] the court apparently attached great value to the wishes of the minor by ordering an evidentiary hearing to solve the problem whether religious beliefs of the parents should dominate rather than the contrary decision of the child.

In an earlier case *In re Seiferth*[165] the court also took the desires of the minor into consideration.

The Seiferth case concerned a 14 year old boy, who was afflicted with a hare lip and cleft palate and needed a rather common operation which promised to greatly improve his appearance and speech, whose father refused to permit the operation because of his belief in mental healing. The Children's Court had the various medical procedures and the results explained to the child. The child, however, expres-

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[163] See e.g. Oakley v. Jackson, 1 K.B. 216 (1914); In re Vasko, 238 App. Div. 128, 263 N.Y. Supp. 552 (1933); In re Rotkowitz, 175 Misc. 948, 25 N.Y.S. 2d. 624 (1941); Mitchell v. Davis, 205 S.W. 2d 812 (Tex. Civ. App. 1947); In re Carstairs, 115 N.Y.S. 2d 314 (Dom. Rel. Ct. 1952). These cases are discussed in: James A. Baker, "Court ordered Non-Emergency Medical Care for infants", 18 Clev. Mar. L. R. (2) 1969 at 304.

[164] See *Supra*, note 162.

[165] 309 N.Y. 80, 127 N.E. 2d 820 (1955).

sed his desire to "try for some time longer to close the cleft palate through natural forces." The Children's Court judge stated that if the child were of tender age and had developed no convictions of his own, an order for surgery would be granted. However, because the boy was fourteen years of age and sincerely believed in the forces of nature and distrusted surgical procedures, no operation was ordered. The Appelate Division, Fourth Department, reversed, holding that the action of the Children's Court in allowing the child to make the choice for himself was improper, that the child was a victim of his father's delusions, and that child's decision was not in his best interests. The Court of Appeals reinstated the trial court's decision. The court stated that, since the Children's Court judge had heard the witnesses, observed their manner, tried to convince both the child and the father of the wisdom of such an operation, and having failed, denied the petition for reasons which he considered more important than the contemplated surgery, these circumstances were such that, "the discretion of the trier of facts should be preferred to that of the Appellate Division."

Indirectly relevant in this context is the position the court took *In re Hudson*,[166] a 1942 case. In this case a mother refused to consent to a surgical procedure for her eleven year old daughter, who was suffering from a congenital deformity of her left arm similar in nature to elephantiasis. This condition rendered the arm useless and was a constant source of embarrassment and the humiliation to the

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[166] 13 Wash. 2d 673, 126 P. 2d 765 (1942).

child. Without the operation the child could never take her proper place in society, but there was a chance that it would not survive the surgery. The Juvenile Court ordered the surgery but on appeal the Supreme Court reversed the decision. The refusal of the parent in this case was not based on religious grounds, but upon a logical fear for the child's life and a reasoned decision that the child should be given the operation, when she became older and capable of giving consent. These facts, together with the absence of an immediate threat to the child's life gave ground to the courts position that the parental care did not fall below that required by statute.

The conslusion from those cases is that the courts are not without sound reason willing to substitute their own authority for parental authority in cases of non-emergency treatment of a child, except may be in cases, where the child is of tender years. In all the cases treatment would have been to the benefit of the health and well being of the clild but apparently that does not constitute sufficient reason for the court to interfere with the parents refusal. The court seemed to try to find a fair balance between the interests of the parent of the state and of the child, but it is hard to derive a definite trend from the cases.

Next we should pay attention to the objections the Alberta Commissioners for the Conference on Uniformity made against the proposed Uniform Medical Consent of Minors Act.[167]

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[167] See *Supra*, note 93 and note 159.

It was suggested that section 4 of the proposed Act[168] may conflict with the provisions of sections 14(3)(x), 15(1) and 17(1)(b) of The Child Welfare Act. These provisions say in sequence that a child may be found a "neglected" child in some cases (see definition at p. 50), that a child, which is believed to be a neglected child, may be apprehended without a warrant by a child welfare worker etc. and that upon apprehension, the child welfare worker may authorize a provision of medical, surgical and psychiatric care without the consent of the parent or guardian.

Section 4 of the proposed Uniform Act is more strict since it requires a dispensation with the consent of the parent or guardian *by order*, where the court is satisfied that the withholding of medical treatment *would endanger the life* or *seriously impair the health* of the minor. [Emphasis added]

Another conflict, although a minor one, is already mentioned in Chapter V.[169] It would be advisable that Alberta specifically deals with these problems concerning neglected children in a possible Consent of Minors to Medical Treatment Act. The Alberta Commissioners only mentioned the conflicts but did not make suggestions as to how to solve the problems.

It seems appropriate to discuss also in this chapter the possibility of conflict between parent and child in cases where a treatment is proposed, which is not to the

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[168] See *Supra*, at p. 48-49.

[169] See *Supra*, at p. 50.

benefit or in the best interest of the child.[170]

The first question we have to solve is whether or not minors, who are capable of consenting to medical treatment, may consent to treatment, which is not likely to their own benefit or in their own best interest. A discussion of the problem is found in Skegg's article on consent in the Modern Law Review.[171] He states that it is not always easy to decide whether a particular treatment is likely to be in the clild's best interests:

> The issues are simplest where the procedure is for the benefit of the physical health of the child--a category which may be taken to include procedures which are for the purpose of assessment and prevention, as well as those which are for the treatment of an existing condition. Problems are likely to arise where the benefit is, at best, indirect. There is an obvious distinction between a case where an infant is extremely likely to benefit from the knowledge gained from a non-theraputic experimental procedure, and one where there is no likelihood of his benefiting; but in some cases it may be difficult to decide where the line should be drawn. However, these difficulties are minor, compared with those arising from the

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[170]Not all procedures which are for the benefit of the child are necessarily in its best interests (as alternative procedures may be still more to its benefit), but the two concepts have been used interchangeably in blood test cases (see also note 151).

[171]See *Supra*, note 5, at p. 377.

question of psychological benefit.

> As discussion of theraputic abortion sometimes illustrates, there is considerable room for disagreement as to whether a procedure is likely to benefit the mental health of a patient and, if so, whether the potential benefit to mental health will outweigh the potential detriment to physical health.

Skegg refers to three unreported cases[172] before the Supreme Court of Massachusetts and all involved the removal of a kidney from healthy infants, for the purpose of transplantation into their identical twins. In each case, the court found that the removal was for the benefit of the healthy twin. The reason given was that the death of the identical twin would have had a grave emotional impact, an impact which (it was said in the first case) "could well affect the health and physical well-being of the healthy twin for the remainder of his life."

There is no uniform opinion as to whether a minor, who may consent to treatment, can consent to treatment, not in his own benefit.

Skegg says about the three above mentioned cases:

> Under English law, the twins would probably all have been capable of consenting on their own behalf, for in each case the court found that the potential donor fully understood the nature of the operation and its possible consequences, and freely consented to it.

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[172] See Skegg's article note 49, also Bowker in McGill Law Journal (see note 8 of this paper) at 178.

Wadlington says[173] that the courts generally only apply the "mature minor" rule and dispense with the requirement of parental consent in cases where the treatment was undertaken for the benefit of the minor rather than a third party.

Bowker says that in case of donations we have to look carefully into the minor donor's capacity to understand the nature, risks and consequences of the operation. He does not seem to be opposed the idea that "mature" minors are capable of giving consent to treatment not to their benefit or in their best interest. Nevertheless he says that the question of risk of harm would have to be considered.

The problem is more complicated in cases where the minor would not have been capable of consenting on his own behalf. Can a parent give legally effective consent to procedures not in the best interest of the child? Skegg thinks that parents can. He says:

> Although the question of benefit raises the most difficult factual issues, the most difficult legal issues arise with those procedures which are unlikely to benefit the infant. In exercising its parental jurisdiction, the High Court will only authorize those procedures which it considers likely to be in the infant's best interests.[174] But it does not follow that a parent can give

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[173] See *Supra*, note 9.

[174] Re L. [1968] P. 119 (C.A.); M. (D.K.) v. M. (S.V.) &G. [1969] 1 W.L.R. 843 (C.A.); and also cases referred to *Supra* in note 151.

a legally effective consent only to such procedures. The cases imply the contrary.[175] This is fortunate, for such an approach would be virtually unworkable. Medically informed persons can often be found to disagree on whether a particular procedure is likely to be in the best interests of an infant.[176] Circumcision of males is a case in point. These disagreements would not cause insuperable difficulties if an application was made to the High Court for an order. But it would place doctors in a very difficult position, if they could rely on a parental consent only where they could be sure that the High Court would order the procedure, as being in the infant's best interests. While it is unlikly that a parent's consent will be effective only where theprocedure can be shown to be in the best interests of the infant, it is even less likely that parents will be held to have an unlimited power to consent to medical procedure on their infants. The courts are likely to adopt some *via media*. One approach would involve making the concept of benefit the sole determining factor. The difficulty of deciding whether a court would consider the procedure to be in the infant's best interests could be avoided. This could be done by providing that the parent's consent be effective, where the parent (and, it could be added, the person performing the procedure) believed (or, alternatively, reasonably believed) that the procedure

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[175] See e.g. R.L. *Supra*, note 173 at p. 132, 135; and S. v. Mc. C., W. v. W. see *Supra*, note 151, at p. 24, 43, 44, and 57.

[176] See *Supra*, note 151.

> was in the infant's interests.[177] Another approach, in which the question of benefit to the infant would play a major, but not necessarily exclusive role, would be to adopt a rule whereby a parent could give a legally effective consent to any procedure to which a "reasonable parent" would be prepared to consent. A speech by Lord Reid, in a recent House of Lords case on the subject of blood tests,[178] gave some indication of the way in which the courts would interpret such a phrase. It was said that, where a particular procedure was in the public interest, a reasonable parent would not require it to be shown to be for the child's benefit before consenting. Rather, he would consent, unless satisfied that it was against the child's interests.[179]

It is doubtful whether the approaaches, which Skegg proposed, are applicable in all cases. His arguments are all based on cases about blood tests on children to prove paternity. Skegg admits that the approaches would lead to different consequences in cases where procedures are in the public interest, like non therapeutic experimentation and tests for teaching and forensic purposes. Applying the first approach in those cases would require "some straining of the concept of benefit."

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[177] G. *Phiri v. R.*, 1963 R. & N. 395, 397 (S.R.), where the court appears to have assumed that the parent could give a legally effective consent to any procedure, which he believed to be for the child's benefit.

[178] See S. v. McC., W. v. W. *Supra*, note 151 and 174.

[179] Ibid at p. 44 and p. 57-58.

Skegg favours the second approach, because it avoids difficulty. He bases his opinion on the 1972 case[180] but warns doctors against possible liability despite parental consent:

> The recent House of Lords case lends support to the second approach, and doctors may safely assume that parents can consent, not only to procedures which are for the benefit of the child, but also to procedures which arein the public interest, and which are not actually against the child's interests. However, they would be unwise to assume that the courts would put his child's interests in jeopardy, whether for the benefit of any other indiviual, or for the public generally.

Personally I have three objections against Skegg's opinion, some of them I already mentioned:

- his opinion is principally based on blood test cases.
- he does not explain satisfactorily the difference between "of benefit to the child" and "in the child's interest".
- he does not pay enough attention to these medical procedures, which have a far more serious impact on the child's health and well-being, than a blood test has.

Bowker is more careful in his opinion about the possibility of a parent consenting to treatment of a child which is not to the child's benefit.

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[180] See *Supra*, note 177.

As far as experiments (scientific and therapeutic) are concerned, I think Bowker agrees with Beecher, where the latter says:

> Parents still have the right to decide whether their children will participate in experimentation, even if not for their direct benefit, provided; the studies contemplated have no discernable risk and have been approved by a high level review committee as necessary and valuable for human progress and do not unfairly take advantage of the child.
>
> and
>
> Research that entails discernable risk may not be performed on subjects too young to give mature and informed consent, unless for their direct benefit.[181]

Bowker however makes some reservations[182] prompted by the results of the case *Bonner v. Moran*[183] with which he disagrees. In this case:

> A fifteen-year old boy donated skin without obtaining his mother's consent. His action against the physician failed at trail but the Federal Court of Appeals directed a new trial because the judge had declined to direct the jury that the mother's consent was necessary. The court held that it was and that a minor could not give an effective consent to this type of procedure.

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[181] Beecher, Research and the Individual: Human Studies at p. 67-68 (1970).

[182] See *Supra*, note 8 at p. 176.

[183] 126 F. 2d 121 (1941) (D.C. Cir).

> The court was not prepared to make an exception for any minor, for the operation was not for his benefit. The significant point in the judgement, however, is the inference by the court that the mother's consent would prevent any recovery by her son.

Bowker states that even when the researcher scrupulously follows Beecher's guidelines, the child may be injured in the course of the experiment. He should therefore be able to bring an action against the researchers and the parent's consent and any release they give should not be binding on the child. He states further:

> Some object that a procedure that is ethical should never expose the researcher to legal liability, at least in the absence of negligence, and that my proposal will discourage needed research. It is suggested, however, that this position avoids the extreme of a rigid "no experiment on children" rule, and the opposite extreme of permitting a parent to bar his child from claiming damages for harm from a non-therapeutic intervention. If guidelines like Dr. Beecher's are followed the risk of harm is slight; but if it materialized the loss should not fall on the child.

It is doubtful whether or not a parent can consent to tissue donation by one of his children. Bowker sets out the problems involved quoting a recent Connecticut case *Hart v. Brown*.[184] In this case;

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[184] 289 A. 2d, 386 (1972).

> The child who required the transplant was just under eight years old and the prospective donor was her identical twin. The parents requested the operation. Without the transplant the sick twin would probably not have survived, and a transplant from the identical twin was more likely to suceed than one from anyone else. A psychiatrist testified that a successful operation would be of immense benefit to the donor "in that the donor would be better off in a family that was happy than in a family that was distressed and that it would be a very great loss to the donor if the donee were to die from her illness." The court held this evidence to be of "limited value", but did attach weight to the opinion of a clergyman that the parents' decision to consent was morally sound. The court held that the parents were entitled to substitute their consent for that of their minor children; and "to prohibit the natural parents and the guardians *ad litem* of the minor children the right to give their consent under those circumstances, where there is supervision by this court and other persons in examining their judgment, would be unjust, inequitable and injudicious".[185] The order was granted.

In his comment Bowker says:

> It is submitted that in general persons incapable of making up their own mind should not be subject to harmful procedures that have no therapeutic value for them. It seems somewhat specious to find therapeutic value to the donor in the psychological prevention of harm to him, as

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[185] Ibid. at 391.

> was done in the Boston cases.[186] The situation that is most troubling is that of the eight-year old identical twins. The likelihood of saving one twin's life is great and the physical risks to the other twin are not very great. Besides the parents strongly favour the transplant. Should the law permit the donation even on these facts?
>
> Notwithstanding the forceful judgment in *Hart v. Brown*, I think not. The taking of the kidney from the healthy twin means that his body has less inviolability than that of anyone else.

We may assume that, in Bowker's opinion, the parental consent given in this case, should also not be binding on the child. This makes the position of the surgeon performing the transplant on the minor donor very vulnerable. He runs the risk of being held liable for assault and battery, because he intentionally harmed the minor by taking away a kidney. If an action is brought against the surgeon, the question is whether or not the court would take into consideration the fact that the minor donor is still able to live a normal life and the fact that a third party benefitted by the transplantation.

However the discussion about experiments and transplantations goes beyond the scope of this paper. It is relevant in so far that, when we propose the draft of a Minor's Consent to Medical Treatment Act, we should take into consideration whether or not it is necessary to provide

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[186] See *Supra*, note 171.

that;

- -a minor, capable of discernment, may only consent to medical treatment, which is not to his own benefit, in cases where there is no serious risk to his health involved.
- -when a minor is under the age of discernment, the parent may only consent to treatment of the minor, where the treatment is to the minor's benefit or not detremental or hazardous for his health and well-being.

VIII

CONCLUSIVE SUMMARY AND RECOMMENDATIOUS

It is unlikely that the foregoing research covers all the problems inherent to the subject of minors consent to medical treatment. On the one hand the research might be too general. Although the access of minors to birth control devices and information is one of the crucial problems, we have not dealt with this specifically. On the other hand the research has to be general to cover the broad spectrum of all medical treatment of minors. We touched on the problems involved in therapeutical and scientific experiments, but only as far as we considered them relevant to the research subject.

Summarizing the following can be said:

1. The common law has established the so-called "mature minor rule" according to which a minor, who fully understands the nature and consequences of a medical treatment, can validly consent to that treat-

ment. The physician can rely upon this consent and does not have to secure parental consent.

2. There are no guidelines as to how to measure minors capability of understanding and it is not clear who should judge the minors capability according to the mature minor rule.

3. There are two criteria for a valid consent:

    1. the consent must be given by a person who is legally competent to consent,

    2. the consent must be informed.

4. In Canada the cases dealing with informed consent allow the physician wide scope in his judgement as to how far he has to go in explaining the nature and risks of the proposed treatment. In the United States there is a trend to greater disclosure, based on the right of every human being to determine what will be done with his own body. It is however doubtful whether or not a minor patient is able to give a consent, which complies with the requirement of full disclosure. This requirement might limit the minor's capacity.

5. It is not clear whether the definition of medical treatment, which is used in various statutes includes prescription of drugs and therapeutical experiments. In American statutes the term health care or medical or health services is used and interpreted as comprehending counselling, preventive and diagnostic procedures and probably experimental therapy as long as it is likely

to benefit the patient and there are no other procedures available.

6. The English and Canadian legislation or proposed legislation favours the age of sixteen as the age of consent to medical treatment, except for the province of Quebec, where the age is fourteen. In the United States the age of consent varies substantially, often depending on the kind of treatment that is needed (e.g. venereal disease, prevention of pregnance, abortion, blood donation). Often there is no age quoted in the statutes, but contain the statutes provisions for emancipated minor, married minors, or minors afflicted with certain diseases.

7. It is not clear whether a doctor can be held liable for assault by prescribing oral contraceptives to minors without obtaining parental consent. He can be held negligent e.g. whenever he does not properly explain the side effects of the pill or when he prescribes the drug without preliminary examination. The situation however is not different from the prescription of any other drug to any other patient (adult or minor).

8. The prescription of contraceptives is unlikely to lead to criminal conviction of physicians because according to the Criminal Code and the Food and Drugs Act, the advertisement, sale or use of contraceptives is not against public policy.

9. The fear that a physician by prescribing contraceptives to minors without parental consent might be found guilty of contributing to juvenile delinquency is not well-

founded. No reported case has been found an a connection between prescription of contraceptives and sexual immorality has not yet been proven.

10. There seems to be enough support for the opinion that parental consent to or refusal of medical treatment for the minor child cannot affect the minor's own consent or refusal to treatment, where the minor is legally capable of giving his own consent and understands the nature, consequences and risks of the treatment.

11. In cases where the minor is of tender years and the parents expressly refuse treatment of the minor, the physician may, in situations where there is a serious threat to the life of the child, invoke proceedings pursuant the child welfare laws. A court order may then justify the treatment by the physician, contrary to the parents wishes.

12. Cases indicate that the U.S. courts are also inclined to order medical treatment of children of tender years contrary to their parents wishes, where the health of the child is not seriously threatened, but an operation will improve significantly the child's condition and the risks involved are not major.

13. No unanimous opinions have been found as to whether or not a minor endowed with discernment, may unconditionally consent to medical treatment, which is not in his benefit and as to whether or not parents, in their parental authority over the child of ten-

> der years, may subject their child to treatment, which might turn out to be detrimental or hazardous to the child's health and well-being.

There are only very few Canadian cases which deal specifically with the problems of consent of minors to medical treatment. The common law is therefor far from clear in this area. With that in mind I would like to recommend:

1. That the province of Alberta enact a comprehesive statute dealing with the consent of minors to health care;
2. That the statute defines "health care" in terms broad enough to include medical, surgical, mental, and dental procedures like coundselling, prescription of drugs, and all preventive and diagnostic and surgical procedures;
3. That the statute reflects a fair balance in the interests of the minors, his parents and the physicians; the interest of the minors being a right to privacy and self determination, the interest of the parents being the parental authority over the minor child, the interest and self determination, the interest of the parents being the parental authority over the minor child, the interest of the physicians being the possibility of treating minors when they need help, without fear of liability;
4. That the age of consent for minors be fixed at fifteen years;
5. That there be further provision dispensing with the need for parental consent in those cases where the minor is under fifteen years of age but capable of

understanding the nature, risks and consequences of a proposed procedure or where he is emancipated, married or pregnant;

6. That the statute contains a provision, codifying the common law principle that in emergency situations, where the life or health of the minor is at stake, parental consent can be dispensed with;

7. That the statute deals in some way with the requirement of informed consent with regards to health care of minors;

8. That the statute builds in certain safeguards as to experimental therapy for minors;

9. That the statute gives a solution for the problem of conflict between parent and child about a proposed procedure; it is adisable to lay down specifically that the parent can never impair the consent to or refusal of health care by the minor, when the minor is legally capable of giving consent;

10. That a possible incongruency with the Alberta Child Welfare Act be solved in the statute;

11. That the possibility be investigated whether or not to regulate situations, in which parents of a child of tender years refuse consent to treatment, which is not necessary tosave the life or health of the child, but will certainly improve the general condition of the child and will give him the opportunity to live a life equal to that of other children;

12. That the statute expressly says whether or not a minor, who is capable of consenting, or a parent for a minor child, can consent to treatment, which is not in the benefit of the child.