# OBTAINING CONSENT FROM CHILDEN (REVISITED)

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*Published in 19:4 Insights at 14, 15, 30 & 31 (Winter 2008)*

## Introduction

In the Summer 2000 issue of *Insights*[1] I considered the issue of counsellors being able to obtain consent from children before providing them with counselling services, and in particular whether counsellors had to also obtain the consent of parents.[2] Because almost a decade has passed since I researched this legal question, and in keeping with the theme of this edition of *Insights*, I have been asked to revisit this issue.

## Does the *Infants Act* apply to counsellors?

As explained in the 2000 article, section 17 of the *Infant Act* provides that a child under the age of 19 may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the child's person, and if the child provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the child's parent or guardian.[3] This provision applies to "health care providers", so the threshold question was whether clinical counsellors fell within that definition. If they did, then section 17 of the *Infant Act* would apply to their practices.

As a result of my research, I concluded that clinical counsellors did *not* fall within the definition of a health care provider, as set out under the Act, and – therefore – counsellors could not rely on section 17 of the *Infants Act* to obtain independent consent from young children. Counsellors were not included in this definition because they had not at that time been designated under the *Health Professions Act*.

The applicable provisions of the *Infants Act* have not been amended during the intervening years. More importantly, counselling has not yet been designated as a health profession under the *Health Professions Act*. For these reasons, I remain of the view that counsellors still cannot rely on section 17 of the *Infants Act* to obtain consent to counselling services from children under the age of 19. Instead, counsellors must look to

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1 Bryce, G "Obtaining Consent from Children" Insights 12:2 (Summer 2000).

2 For the purposes of this commentary I will use the term "parents", but this should be understood to include the legal guardians of children or adoptive parents, and not just their biological parents.

3 As I had noted in 2000, the *Infants Act* uses the term "infant" which is defined to mean someone who is under the age of nineteen. I prefer to use the term "child", as an infant is commonly understood by most of us to be a very young child, usually a child under the age of two. Therefore, while the legislation uses the term "infant" I will use "child" in this article.

another source, just as they had to in 2000.

**Can counsellors rely on the common law rules of consent?**

In the 2000 article, I went on to explain that, because the *Infants Act* has "encoded" the basic common law rules that apply to obtaining consent from children under the age of 19, and because the Act also expressly states that it does not replace the common law, counsellors should be able to rely on the common law rules when seeking to obtain the consent of children. I remain of that view today.[4]

There have been few reported cases from BC that have considered the application of the *Infants Act*. The leading case arose in 1993: Ney v. Canada (Attorney General).[5] In Ney members of a religious advocacy group, the Citizens' Research Institute, sought a declaration that what is now section 17 of the *Infants Act* be deemed unconstitutional and an infringement on the rights of children and parents, as protected under the *Canadian Charter of Rights and Freedoms*.

In rejecting the CRI's application to strike-down the child consent provisions of the *Infants Act*, Huddart J. reviewed the common law rules that govern the right of children under the age of 19 to consent (or to refuse consent or to withdraw consent) to health care. As I explained in 2000, under the common law counsellors should be able to obtain the separate consent of a child to counselling services. It is useful to review those rules again and consider some cases that have applied the common law.

**What are the common law rules on consent by children?**

Under the common law, a child under the age of 19 considered capable of giving legally binding consent to a health service without the need for the practitioner to seek the consent of that child's parent(s) or guardian(s). But, before obtaining or relying on the child's consent, the practitioner must determine three things:

> (1) That the child understands and appreciates the nature of the treatment or service that is being proposed, as well as any reasonably foreseeable risks that might arise. This necessarily involves the counsellor ascertaining that the child has sufficient intelligence to be able to gain such an understanding.
>
> (2) That the child has the capacity or the ability to give or express his or her consent, which could be given verbally or even with a gesture.

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[4] In the Ney case, *infra*, Hubbard J. suggested at para. 34 that the common law rules that allow practitioners to rely on the consent of children apply only to "health care providers whose professions are regulated by statute". However, that comment was *obiter* and not central to the issue being decided in that case. Further, given the range of health professions who are not yet regulated by statute, it makes little sense to limit the scope of the common law only to the regulated professions.

[5] Ney v. Canada (Attorney General) 79 B.C.L.R. (2d) 47, [1993] 6 W.W.R. 135, 102 D.L.R. (4th) 136 (BCSC).

(3) That the proposed counselling service is in the child's best interest.

The first precondition is not a fixed test. It will vary depending on the nature of the treatment or service being proposed, and any associated risks.

For example, if the nature of the therapy were minor or straightforward with little risk to the child, then less understanding may be required than if the treatment was more complex or posed a greater risk to the child's health. The practitioner must provide the child with information that a reasonable person would require to understand the services bring offered and then make a decision. This would include disclosing information about the nature and purpose of the service or therapy, and any risks and benefits a reasonable person would want to know about. Alternatives to what is being proposed should also be discussed, if applicable. The child should be given an opportunity to have any questions about the services or therapy answered.

The capacity of a child to consent is not a switch that suddenly turns on or remains on in all circumstances. "[The] parental right to consent to a child's medical treatment exists only when the child is not capable of granting or refusing consent. This is not a sudden passing of the power but rather a gradual relinquishment of the decision-making power from the parent to the child as the latter's maturity and intelligence increases."[6] Thus, the further a child matures, the more likely he or she would be able to consent to more complicated or risky services.

A counsellor should carefully record in the clinical notes what process was followed to ascertain whether or not the child understood and appreciated the services being proposed and the risks. This would include any conclusions the counsellor may have reached about the child's intelligence and capacity to understand. A counsellor who is not skilled in performing such assessments should consult with another health care provided who is trained and experienced in these matters.[7]

The second precondition may not arise in a counselling practice, but if a child cannot communicate consent for some reason (even if the child appears to have sufficient intelligence to understand, etc.), the counsellor should obtain consent from some other source, such as the child's parent.[8]

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[6] Huddart J. in Ney, *supra*, a para 31.

[7] Huddart J. in Ney, *supra*, a para 30 also suggested that physicians alone should make such determinations: "[The] authorities [indicate] that it is the medical practitioner rather than the parents who is to determine whether the minor is capable of consenting." And later at para 33: "It appears that the medical practitioner is to make this determination." However, an assessment by a medical practitioner may only be necessary where the nature of the proposed health service involves serious or substantial risks to the child.

[8] In "Consent for Conselling Children During Marital Breakdowns", *Insights* 13:3 (Winter 2002), [posted at: www.bc-counsellors.org/martial.aspx] Martha Sandor and I explained that, if both parents continue to have joint custody of a child, then the counsellor can rely on the consent of either parent. While consent from both parents would be desirable in practice, from a legal point of view a counsellor does not have to obtain the consent of both custodial parents, which can be difficult to obtain if they are involved in a marital dispute or custody battle and have taken opposing views on the need for counselling.

To satisfy the third pre-condition, a counsellor should then make inquiries to ensure that the proposed counselling service is in the child's best interest. It may be useful for the counsellor to consult with the parents, as they may have information about important aspects of child and his/her personal, family, religious or health circumstances that the child may not be aware of. However, it should be kept in mind that the best interests of the child is assessed the standpoint of the child and not from the standpoint of the parents. The counsellor should ensure that the child is comfortable with any negative opinions that have or may be expressed by that child's parents. Again, the counsellor should document such conversations in the clinical notes.

Finally, the counsellor should be comfortable that the child's consent is being given voluntarily and not as the result of undue pressure or fraud. Consent in such circumstances is void, even if the other conditions have been met.

The sort of child who is capable of understanding and giving informed consent is commonly referred to as a "mature minor". In summary, therefore, if counsellor is satisfied that the conditions outlined above have been met, the counsellor should be able to provide the intended counselling service to the mature minor in question with that child's consent and without fear of parental retribution.

It is useful to present a few examples from reported cases where the courts have found that mature minors are capable of giving (or even withholding) consent without having to also involve their parents. These examples will serve to illustrate how the common law rules have been applied in the past.

**Examples of mature minors**

I have found no reported Canadian cases that have considered the issue of a mature minor consenting to counselling services. No doubt because of there is often a need for the potential damage award to be substantial; most the reported cases have considered consent or refusal in relation to medical treatments.

- In C. (J.S.) v. Wren, [1987] 2 W.W.R. 669 at 671 (Alta. C.A.), the court found that a 16 year old girl was of sufficient intelligence and maturity to give valid consent to an abortion that her parents opposed.
- In R. v. W. (D.D.), (1997) 114 C.C.C. (3d) 506, 90 B.C.A.C. 191, 147 W.A.C. 191, [1997] B.C.J. No. 744 (BCCA), the Court of Appeal ruled that a 16 year old girl was capable of refusing to provide a sample of her blood for DNA testing that was sought by her mother's brother for the purposes of proving that he was her father.
- In Van Mol v. Ashmore (1999) 168 D.L.R. (4th) 637, 116 B.C.A.C. 161, 190 W.A.C. 161, 58 B.C.L.R. (3d) 305, 44 C.C.L.T. (2d) 228, [1999] 6 W.W.R. 501, [1999] B.C.J. No. 31, 6 W.W.R. 501, 1999 BCCA 6 (BCCA), a doctor was found negligent in performing surgery that resulted in a permanent, disabling injury to a 13 year old girl because only she (and not her parents) who could give informed consent. Because the doctor failed to disclose to her a significant risk of the surgery that then occured, that failure to disclose negated her consent.

**Disclaimer**

This column is intended to help clinical counsellors gain a better understanding of legal issues that are relevant to their practice. It is not a legal opinion, nor is it meant to be a substitute for independent legal advice. Neither the BCACC nor Mr. Bryce can provide individual counsellors with legal advice and they assume no responsibility for the content of this column. If you have a particular concern about an issue that you are facing in your practice, you should seek legal advice from your lawyer.

**What other legal issues interest you?**

If you have a practice question that you feel raises a legal issue that should be of concern to all counsellors, please mail that question and any background information in confidence to: The Counsellor's Counsel c/o the Victoria office.

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Quotable quotes:

*"A minor is capable of consenting to medical treatment to the extent that he or she can appreciate fully the nature and consequences of the medical procedure to be performed for her or his benefit. That common law rule has been little affected by [the Infants Act, which primarily fixes] an age at which a child is deemed capable of consenting." [Huddart J. in Ney v. Canada (Attorney General) 79 B.C.L.R. (2d) 47, [1993] 6 W.W.R. 135, 102 D.L.R. (4th) 136 (BCSC) at para. 14.]*

*"The common law does not fix any age, below which minors are automatically incapable of consenting to medical procedures. It all depends on whether the minor can understand what is involved in the procedure in question. ... [M]any children under the age of ten would probably be capable of consenting to relatively minor and straightforward medical procedures." [Professor Skegg quoted by Gosse, R. in "Consent to Medical Treatment: A Minor Digression" (1974), 9 U.B.C.L.R. 56, at pp. 61-62.]*